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ORIGINAL LECTURES.

EXOPHTHALMIC GOITRE; DYSPEPSIA; PROGRESSIVE MUSCULAR ATROPHY; CHRONIC DIARRHŒA.

A Clinical Lecture Delivered in Jefferson College Hospital on February 25,

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The first case, gentlemen, that I will bring before you to-day, is one that will well illustrate the method of therapeutics as based upon a physiological basis, about which I have already spoken to you on several occasions. Exophthalmic goitre, as you no doubt are aware, is a disease characterized, so to speak, by four sets of symptoms: we have an implication of the eyes, they are prominent and protruding; we have an implication of the thyroid gland, which is hypertrophied; we have a dilated condition of the blood-vessels generally; and we have the heart affected, in so far as its action is increased in frequency and in force. We have, then, this complexus of symptoms in typical cases, but of course it is not in every case that we have all of them present. In this case, for example, there is no protrusion of the eyes, though the other symptoms are all well-marked.

Now observe this young man's general appearance, if you please; see his type of skin; now he is sitting quiet and has been for some time, and yet you notice that his skin is redder than it should be normally. When he makes any exertion, simply that of walking, or goes into a warm room, there is a very decided flushing, not only of the face, but of the whole body; in other words, there is at all times a dilated condition of the peripheral vessels, which is increased by the least exertion. Such a state of the cutaneous circulation is always present in this disease, and the temperature is naturally higher than it is in health, which you would expect. Well then, we have also an increased rapidity and force of the heart's action, which is really a compensatory augmentation, made necessary by the dilatation of the peripheral vessels, in order that the circulation may be properly maintained therein. Well now, where shall we look for an explanation of these phenomena, which we must recognize as due to a paresis of the vaso-motor nervous system? well, so much for this cause, but that we may have a comprehensive view of the disease, we must endeavor to look further and ascertain, if possible, what has been the ultimate cause of this paresis of the vaso-motor system. There seems, from clinical experience, no grounds for doubt that some mysterious and as yet but imperfectly comprehended connection exists between this hypertrophied condition of the thyroid gland and the paretic condition of the vaso-motor system. Just how the connection acts we are not prepared to say, but that it does exist I think there can be no doubt.

As I have already said, in this case we have no protrusion of the eyes, but we have a marked enlargement of the right half of the thyroid gland. When I place my fingers over this gland I can detect a very distinct pulsation therein, not confined to the skin alone, for, on somewhat deep pressure, I can also feel this pulsation deep down in the tissue of the gland itself. Now I have said that this gland exerts a mysterious influence; let me revert to it again for a minute. You are all no doubt familiar with the fact that very peculiar effects follow the removal of the thyroid gland, and you have also, no doubt, heard of the disease called myxœdema, which is characterized by, and is the result of, atrophic changes in this gland, just the reverse of what we have in this case. So that you see this body certainly must play some important part in the economy, though just what it is we do not know. Here, instead of atrophic, we have hypertrophic changes, and the vaso-motor nervous system affected in consequence.

Well now, as I have said, we will treat this case from a physiological basis; we will use such drugs as are calculated to antagonize the conditions that are here present. In my didactic lecture this morning I was discussing the therapeutic properties of the two drugs, nitrite of amyl and nitro-glycerine, and I told you that if you were to administer nitrite of amyl to a patient you would produce, in consequence thereof, a fulness and a throbbing of all the blood-vessels, just such a condition as we see so well-marked in the case before us; therefore, reasoning from a physiological standpoint, we should obviously employ such drugs as are calculated to oppose, to antagonize this condition. Well now, what drugs are the antagonists of such articles as nitrite of amyl and nitro-glycerine? We have several, prominently among them being ergot, which not only theoretically opposes this action, but which has been amply demonstrated by clinical experience to do so. Dr. Barnes, of London, has reported cases of hour glass

contraction of the uterus—which is a condition that may be likened to that produced by ergot, and which is a condition that does not usually readily subside spontaneously—wherein he has secured most satisfactory results from the use of nitrite of amyl, thus very clearly demonstrating the antagonistic action of these two drugs.

Having here, then, a condition analogous to that which would be induced by the use of nitrite of amyl, it is obviously logical, arguing from the basis of the antagonism of drugs, that we should employ ergot to combat such a condition. I will therefore order ergot for this patient, and I ask, is there any other drug that has this same character of antagonistic action? to which I answer, yes; that such virtue is undoubtedly possessed by digitalis, so that I will order a pill containing two grains of Squibb's aqueous extract of ergot, and one grain of powdered digitalis leaves, one of these pills to be taken thrice daily. Well, now, when we have ordered these pills have we performed our full measure of duty? No, by no means. We must then direct our attention to the enlargement of the thyroid, for the ergot and the digitalis are intended to combat the abnormal state of the circulation.

When he throws back his head you can plainly see how decidedly enlarged this gland is. To reduce this enlargement, I know of no better remedy than the local use of an ointment of the red iodide of mercury, which will usually relieve a thickened, hypertrophied condition of the thyroid. The Indians, from whom we have derived this remedy, always rubbed it in in the direction of the rays of the sun. I do not know whether this procedure has any superiority over any ordinary method of applying it, but it can certainly do no harm, and we might resort to it. The patient might sit in front of a window, so that the rays of the sun would fall on his throat. There are certain rays of the sun outside of the solar rays, that is to say, the chemical or actinic rays, that certainly do have an influence on vegetable life, and may have some influence on animal life, and we might as well avail ourselves of any influence that these rays may possibly have, for, as I have said, they can do no harm. I said to use an ointment of the red iodide of mercury. Now, a word of explanation will be necessary, or else you may be misled by what I have said. This ointment was officinal in the Pharmacopœia of 1870, but is not so in that of 1880; but you can easily make an ointment by using one drachm of the mercury to one ounce of simple ointment, and take a piece the size of the end of your thumb and rub it well in. Do this once a day until the skin becomes sore. After awhile you will notice that the skin will become dry and the epidermis will peel off, but this does no harm. You may then suspend the ointment for awhile, recommencing it later and using it a little more cautiously than at first.

DYSPEPSIA.

This young man comes to us complaining of vomiting. This may seem like a trivial case to bring before you, and the man does not look as though he was very ill, but it is just these apparently simple cases that will baffle you if you do not cultivate the habit of critically inquiring into their cause and nature. You must not despise small matters, for if you do you will frequently overlook greater ones. There are several points of interest about this case. He tells us that he vomits some time after eating, and that the ejected matter is liquid and occasionally there is some solid matter mixed with it. When he was in the waiting-room awhile ago he was given a draught of water, and after about half an hour it was regurgitated. Now there is a difference between vomiting and regurgitation that I will explain to you. In vomiting there is not only a contraction of the stomach, but the abdominal muscles also take part in the act; whereas in regurgitation it is only the stomach and œsophagus that are involved, and regurgitation may occur without any implication of the stomach even, being simply an inversed peristaltic action of the œsophagus. We will sometimes have cases where the œsophagus is dilated, where a pouch is formed in some portion of its course, from which the food, after remaining therein for a time, is regurgitated. Such is not the case here, for the contents of the stomach itself are regurgitated. That is the problem that confronts us, namely, to find out why this regurgitation takes place; and until we have done so, we cannot hope to institute a rational course of treatment that will inure in the least to the patient's benefit.

The matter regurgitated is, as I have told you, liquid, and I assume that the man has a form of dyspepsia. Well, what form is it? If we were to give this man remedies directed to the relief of the vomiting, even though we were to restrict his diet, as such restriction is usually understood, we would most likely fail to effect a cure, because there is a special indication in the case that must be taken into consideration, and it is just here, in recognizing and appreciating the significance of these little symptoms, that the superiority in diagnosis and the greater success in treatment of one physician over another is to be found. We must work out our therapeutics on the fundamental principle that the matter here regurgitated is liquid; hence the patient must be restricted to a dry diet; he should confine himself to solid aliment, and take only that amount of liquid that is absolutely necessary to the proper performance of his functions. Of course, he could not absolutely abandon liquids, for they seem to be really more essential to health and life than do solids. This fact was abundantly demonstrated by Dr. Tanner, in his famous fast. He found it comparatively easy to get along without solid food, but his great trouble was in giving up liquids, so much so that after seven or eight days his desire, his longing for them, became well-nigh irresistible. So that I say water is really more essential to the performance of the functions than is solid food; we could get along for a longer time without solid foods than we could without liquids. When we do not use liquids, the liquid constituent of the blood becomes very much diminished thereby, the blood, in consequence, is thickened, and so an embarrassment of the circulation ensues. Taking this fact into consideration, it would

not do to rigidly exclude liquids from this man's diet, but, to repeat, he should take them only in such quantities as are absolutely essential. He should take no fluid at meals, unless it is necessary to aid him to masticate his food, and then he should take only a few drops at a time. He should also avoid all articles that are liable to undergo fermentation in the stomach. He doubtless eats fats, which undergo fermentation, with the liberation of butyric acid, and also, no doubt, saccharine articles, that liberate acetic acid and carbonic acid gas, and I will venture to say that he is troubled with eructations of gas; well now, he should avoid such articles. To summarize, his diet should be dry and should consist of such articles as are free from saccharine and oleaginous matter. Now, in addition to the regulation of the diet, which is the most important consideration, what drug can we use? I have, in such cases, derived very good results from the use of sulphurous acid (mind, I say sulphur*ous* and not sulphur*ic*), of which we will give him ten drops (of the dilute acid) in a wineglass of water, thrice daily, before meals. This drug, in conjunction with the regulation of the diet, will do a great deal of good.

PROGRESSIVE MUSCULAR ATROPHY.

The characteristic attitude of this woman's hands is so striking that we have no trouble in making a diagnosis. You see that she has wrist-drop, but I do not say that she is suffering from lead-poisoning, with which trouble you might, at first sight, confound this condition, because she is not so affected. You must remember that there are many varieties of wrist-drop. So far as the cause is concerned, the condition is not always due to plumbism, and you should bear this fact clearly in mind, else you will be often misled in your diagnosis. You will also note how all the muscles about the fingers, the interossei very perceptibly, are wasted. When I examine the shoulder, I feel the spine of the scapula very prominent, while both above and below it, more especially below, there is a marked depression, which tells me that there is a wasting of the muscles in this region. She can raise her arm from her shoulder, by which I know that there is still power in the deltoid, but this power is noticeably diminished. Now, then, we have evident wasting or atrophy of the muscles in a muscular young woman, who works in a manufacturing establishment. It is a case of progressive muscular atrophy.

This disease is not very common in women, but it does quite often occur in men under just the conditions that we have here; that is to say, it usually occurs in strong, muscular men, and is the result of some over-exertion. It is sometimes hereditary, that is to say, a tendency to atrophy may be inherited, and in such cases over-exertion will light up the latent inheritance into activity. It will be observed, that is this tendency, in certain family groups. It nearly always commences in the fingers, and first manifests itself by sensations of pain and trembling of the fingers and hands. So also, in these parts, there is always a reduction of temperature. Now we will test the electrical reaction of the muscles; you see that every interruption produces a contraction of the muscles, but it is impaired; it is not as marked as normal, and it is confined to certain groups of muscles, but although the muscles are much wasted, they yet respond fairly well to the faradaic current; they react quite well to the direct, but less so to the indirect current. Well, now, what does this response indicate? It tells us that all the muscular elements are not gone, that while the muscular tissue is, to a great extent, replaced by fibrous tissue, it is not wholly so usurpated, and this is a point of exceeding great importance, for upon the loss or the conservation of this reaction will our prognosis depend. Since we find that the muscular tissue still remains, we may hope to rejuvenate it. I would say that in this case there is wasting of the muscles, and that while the response is feeble, yet they do respond to direct faradaic excitation, and much more readily to galvanism. We have, then, a condition where the muscles are not completely changed in character, but are mainly atrophied, the muscular elements are in fairly good condition, and we may therefore hope to benefit the patient. Let us see what the difference in temperature is, and for this purpose we will use one of these surface thermometers that are made by Hawkesley, of London, and are so arranged that a large surface of mercury is exposed to contact with the skin. We might make comparative observations of temperature, if we wish, though it is sufficient for all practical purposes to know that it is lower in the affected part, and we usually find it several degrees lower. In this case we find the temperature of the cheek to be 99°, while that of the thumb is only 92°, a difference of seven degrees, which is very great even in this disease.

The question of the seat of the lesion in progressive muscular atrophy has been greatly discussed and is, as yet, unsettled. One of the latest authorities who has written on the subject is a distinguished professor of Heidelberg, who has contributed a lengthy monograph, in which he claims that the disease really begins, that the lesion is situated at the point where the disease first becomes manifest, that it is situated in the terminal filaments of the motor nerves, and that it is transmitted to them through the muscles, having been really in the first place an affection of the muscles themselves, from which theory the disease would seem to be rheumatic somewhat in nature. The opposite view is that the lesion is situated in the multipolar ganglion cells of the anterior cornuæ of the spinal cord. This case would seem to indicate that the theory of the Heidelberg professor was the correct one, for the electrical responses would cause us to think that the disease was purely a local one, and consisted simply in an atrophy of the muscles without, as yet, any implication of the nerves.

Well, now, assuming this to be the correct theory, what treatment would be indicated? Well, as the muscles respond to the faradaic current, it would be obviously proper for us to excite them thereby until they are restored to their full volume and normal reaction. If they did not respond to faradism we would employ galvanism, but as they do respond to the former, it will be used. Well now, is there anything else we can use in addition to electricity? Yes, we

can probably accomplish a great deal by local medication; we will inject $\frac{1}{60}$ of a grain of strychnia into the affected muscles about three times a week, and will also look to improving the general health.

CHRONIC DIARRHŒA.

This young man tells us that he has chronic diarrhœa; that is, to speak more correctly, he will have attacks of diarrhœa every now and then, which will last for several days each time. The stools are liquid, watery and yellow in color. He is never constipated, the passages being always more or less soft in consistence. I have brought the case before you more especially to speak of its treatment. The discharges contain no pus, no blood and no mucus. Now, here again we will base our treatment of this case upon physiological principles. There is evidently a congestion of the intestinal mucous membrane, and we ask what drug will combat such a condition. There is none better than belladonna, and we will give this patient 15 drops of the tincture thrice daily; we will give it alone, that we may unequivocally note the effect. Belladonna is sustained in its action, and it may therefore be that after a while two doses will be found to be sufficient.

ORIGINAL ARTICLES.

EARLY AND REPEATED TAPPING IN CASES OF ASCITES.[1]

BY AUGUSTUS P. CLARKE, M.D.,

OF CAMBRIDGE, MASS.

I was called on March 17, 1879, to attend A. V. S., a Hollander, aged 56 years. He was a cabinet-maker, and while returning a distance of two miles from his work began to suffer from a severe attack of dyspnœa. He had always been well until that time, when he walked somewhat faster than usual. The walking seemed to be the first exciting cause of his malady. When I saw him he was quite unable to lie in a horizontal posture on account of the extreme dyspnœa. Counter-irritants, expectorants and stimulants, with ammonia, afforded some relief, and the next day he was much easier.

I did not visit the patient again until January 20, 1880, when I was called, and learned that he had suffered much in the meanwhile from occasional attacks of dyspnœa, as well as from œdema of the feet. At this time he was suffering from orthopnœa. His feet and legs were greatly swollen, and his urine was scanty, the amount voided in twenty-four hours being not much over a pint. The urine, when boiled, gave a precipitate of albumen, one-sixth, the specific gravity was 1014. Both lungs were evidently more or less œdematous, and this appeared to be the cause of the orthopnœa. The patient also suffered a good deal from cerebral symptoms; he was delirious, and unable to sleep, and hypnotics acted badly. He had always been of temperate habits. He also suffered from dimness of vision; the ophthalmoscope revealed marked retinitis of both eyes. The infusion of digitalis in full doses was given, and followed up until the physiological and therapeutical action of that drug was obtained. Elaterium in pill, gr. $\frac{1}{6}$, was given every second or third day. Sometimes the pill had to be repeated the same day. I also scarified the legs and feet from time to time, and by this means I succeeded in reducing the swelling very much. My record shows that I made upwards of a thousand punctures with the lancet. The scarifications were followed by no untoward symptoms, and the patient often requested the scarifying to be done for the relief afforded.

Subsequently Martin's elastic bandage was applied to each leg from the toe to above the knee. These afforded him a good deal of relief, and after he had learned their uses and value he would rarely be without them. His symptoms at length became better, the swelling of the extremities was markedly less, and the dyspnœa much less urgent. The action of the lungs became more regular, and the pulse and temperature were nearly normal, but he began to suffer more from ascites; and though the diuretics and hydragogues were freely employed, they had but a limited influence on the fluid effused into the peritoneum. Fluctuation became distinct, but I waited until August 20, 1880, when with the aspirator I removed four quarts of fluid from the cavity of the peritoneum. This gave the patient considerable relief, and on September 11 I again drew off eight quarts. The patient bore the loss quite well, and afterward appeared much better.

On October 13 I drew off with a small trocar five quarts. On November 14 I drew off four quarts, and January 18, 1881, I drew off with a larger trocar 8½ quarts; March 18, 11½ quarts; April 21, 15½ quarts; May 14, 16 quarts; June 10, 18 quarts; July 16, 16 quarts; August 6, 14½ quarts; September 3, 16 quarts; October 1, 17½ quarts; October 28, 13 quarts; January 5, 1882, 12 quarts; February 10, 14 quarts; March 14, 14½ quarts; March 27, 17 quarts; April 17, 18 quarts; May 8, 17 quarts; May 22, 13½ quarts; June 5, 12 quarts; July 11, 14 quarts; August 22, 12½ quarts; March 30, 1883, 11½ quarts (after a period of six months and eight days); August 14, 14½ quarts (after a period of five months); September 7, 12 quarts; October 21, 15 quarts; December 17, 13 quarts; January 25, 1884, 14½ quarts; February 29, 15 quarts; April 7, 17½ quarts; July 7, 13½ quarts; October 3, 13 quarts; November 19, 16 quarts; December 17, 12 quarts; February 21, 1885, 13 quarts; and April 17, 13 quarts. The number of tappings, including the two aspirations, was in all thirty-eight, and the quantity of fluid removed by this means of treatment amounted in all to 506½ quarts (32 fluid ounces contained in each quart, or 126⅝ gallons).

After each tapping the patient was always better, and was often able to go out of doors, especially in warm weather. Soon after I began to tap him he gained in strength, nearly all the œdema of his lower limbs disappeared, his appetite became better, and for the most part he needed no quieting medicine;

[1] Read before the Cambridge Society for Medical Improvement, January 25, 1886.

indeed, he took but little medicine after this line of treatment was adopted. The patient also began to take quite a lively interest in various matters, such as reading the daily papers, until the accumulation of fluid become excessive. The urine became of higher specific gravity, for a long time, on boiling, was only a little opalescent, and there was a tendency to a return of its normal constituents. The quantity of urine for a healthy person was only approached; it never exceeded 1,000 cc., and for the most part was only 500 cc. daily. Accurate measurements were kept for a long period daily. Whenever the quantity of urine for any considerable time was increased, the symptoms and condition became much better; and whenever the quantity of urine was markedly less, say between 400 and 500 cc., the patient was more uncomfortable.

The longest period between the tappings was six months and eight days. This was from August 28, 1882, to March 3, 1883. The next longest period was that of five months, from March 3 to August 4, 1883. During these periods the patient took from time to time a good deal of fluid extract of jaborandi and of ergot. The patient felt so far recovered for awhile as to be out a little almost every day. The urine during this time was greatly improved and he gained in strength. For several weeks the circumference of his abdomen over or just below the navel was no more than it often would be three or four days after a tapping. Toward the close of these periods the fluid increased quite rapidly, and the tension became intolerable. The patient usually recovered well after each tapping. Sometimes, however, he would feel a little weak, but a small draught of wine or of milk, or sometimes only water, was all that was needed to revive him. He usually kept his lounge or bed for a day or two, and then dressed himself as usual. A short time before he was tapped in December, 1884, he met with a severe fall down a long flight of stairs. He was severely contused about the right shoulder, left hip, leg and other parts, but he sustained no marked injury upon the abdomen.

During the early part of his sickness he had considerable febrile disturbance, the pulse often going as high as 115, and the temperature as high as 101.5° to 102° F.; but for a long time before his death the pulse was normal or nearly so, and there was no rise of temperature. Immediately after being tapped the temperature would occasionally be slightly sub-normal. At first the patient suffered very much from constipation, but for the last three years of his life the bowels were very regular. Though the urine was scanty, and at first highly albuminous, very few casts of any kind were observed, or other abnormal products of a microscopic character. After he was tapped he assumed the horizontal posture.

The liver, for the last two years or more, could be distinctly felt as a hard and contracted globular mass high up in the right hypochondriac region. It was evidently not more than one-half the natural size. At first the area of the liver by percussion appeared to be unusually extended, and this increased size at first, occasioned by congestion or inflammation, would account in part for the increased temperature and other febrile disturbances which appeared so early in the case. The diminished flow of the urine was under the circumstances indicative of congestion of the portal vein. The increased bulk of the liver, and the commencing ascites and the œdema of the lungs must have greatly interfered with the action of the diaphragm, and have been the cause of the extreme dyspnœa which also so early presented itself.

The last six months or more of the patient's life showed a general failing of the vital powers; the appetite was poor, though the patient was not greatly emaciated. About May 1, 1885, he began to be troubled with dysenteric stools. These exhausted him more and more, so that his death could be considered rather as the result of gradual asthenia than of any peculiar lesion or organic phase of the disease. The tapping, as already stated, gave immediate relief from the dyspnœa and other urgent symptoms, and the patient, though dreading the operation, at length became satisfied that he could not be comfortable without resorting to it. He showed me an account which he had found in reading an old Dutch author, that Peter the Great had saved or prolonged the life of his wife, Eudoxia Feodorovna, by tapping her for a dropsical malady. This art, it appeared, Peter had learned by witnessing the operation as performed by the chirurgeons when he was a young man and an inmate in a European hospital. This little bit of history served to stimulate my patient by giving hope and confidence in the treatment as the only means for his relief. He died on May 13, 1885.

In regard to my own experience, reference to the recorded cases of ascites from various causes coming under my care up to the time I was called to treat the case here reported, shows that six cases recovered; one case after a single tapping, one case after three tappings, two cases after four tappings each, one case after three tappings, each tapping varying from two to three months, and one case, that of a lady aged 51, after six tappings, each tapping varying from six weeks to three months. There was no sensible return of the fluid in her case after a period of two years. After that she left the State for the provinces, and has not to my knowledge since returned. One case was that of a man, aged 64, whom I tapped for ascites four times during a period of three years. He was greatly relieved, but afterwards died from some abdominal disease complicated with acute pneumonia.

Two cases were males, aged respectively 37 and 42. These were phthisical patients, each much troubled with ascites. One of them was tapped twice, and the other three times during a period of eleven months. They were greatly relieved, but both finally had to succumb to the original malady, which was far advanced before this treatment was undertaken.

Another case was that of Miss S., aged 17. She was under my care from July to September, 1878. She had Bright's disease. She had previously been under the treatment of two homœopathists for what they at first supposed to be "rheumatism and neuralgia of the spine," until the legs and abdomen began to swell, when they were dismissed and I was called and diagnosticated, with Dr. Holt's assistance,

Bright's disease. We were compelled to tap her twice within two months, but she finally died in a uræmic convulsion. Her abdomen was enormously distended before the tapping. This was undoubtedly a case of acute parenchymatous disease of the kidney.

Another case was that of a lady aged 60 years. She had malignant disease of the stomach. She also had ascites. The fluid, though moderate in amount, was a source of great suffering, and she required large doses of morphine. She was under my care from February 5th to April 25th, 1878, the time of her death. I tapped her twice. She experienced marked relief from each tapping until the fluid again accumulated, which did not occur until after the lapse of four weeks.

The twelfth case was that of Miss P., aged 43 years. She suffered from extreme dyspnœa and great throbbing at the neck, which seemed indicative of aneurism. Elaterium and digitalis removed all the swelling of the extremities and abdomen. This was from November 1 to December 16, 1879; but on December 31 following she had a recurrence of the dyspnœa, with marked ascites. Between this date and March 10, 1880, she was tapped twice, with much relief after each operation. On April 3 she died in consequence of the enormous aneurism, which after death proved to be at the arch of the aorta.

I will now briefly relate a case which has been of unusual interest to me. Mr. B., aged 76 years, upon whom I had operated three times during the months of May and June, 1884, before I succeeded in completely curing him of old hæmorrhoids attended with severe prolapsus of the rectum. After this the patient had entirely recovered, so that he was able to be out as heretofore during the months of August and September. In November following he was run over by a heavy express wagon while in Boston, and was afterwards exposed to severe cold and wet, and was chilled. On November 11 he was unable to void urine. His legs, genitals and abdomen were enormously swollen, and the patient became stupid; his tongue was dry and brown. With great difficulty I succeeded, on that day, in drawing off about a pint of urine, which was of a dark, smoky color. On the next day he was much worse; was still stupid and unable to comprehend anything of consequence when spoken to, and I found it necessary to slit up the prepuce about an inch and a half before I could reach the urethra with any kind of a catheter whatever, so great was the swelling that had extended to these parts. Only a small quantity of urine, however, was found in the bladder. With the assistance of the apothecary, Mr. H. S. Andros, who had frequently assisted me in the case of A. V. S., I aspirated the abdomen and removed four quarts of fluid. The next day I tapped again, and the amount of fluid now removed was nearly a water-pailful. After that the patient was able to void his urine, and by the use of elaterium he gradually made a complete recovery, except for a troublesome pruritus, the absence of the tendon reflex and a tendency towards locomotor ataxia. The patient is able to be out of doors almost daily, and walks quite well. Up to the time (1880) when I began to treat my patient, A. V. S., almost all authorities refer to tapping of the abdominal cavity in ascites to be had recourse to only as a last resort. In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 1, No. 10, will be found an original article "On Early Tapping in Cases of Ascites." This article, by Austin Flint, M.D., was read at the meeting of the British Medical Association in Liverpool, on August 2, 1883, and which was about three years after I began to treat my patient, whose case I have given *in extenso* at the beginning of this paper. Dr. Flint, in speaking of the advantages of early tapping in cases of ascites, gives a report of twelve cases illustrative of the benefit of such tapping. He refers to a series of forty-six cases in an article "On Hydro-Peritonæum," which he published in the *American Journal of Medical Sciences* in the year 1863. In his article of 1883 he again states that more writers than heretofore recommend tapping in cases of ascites "only when the dropsical accumulation has occasioned an alarming interference with respiration, and after other means of treatment have proved ineffectual." In a foot-note he mentions "as exceptional instances" some cases occurring in Dr. Frederick T. Roberts's "Hand-Book of Medicine."

QUININE IN SCIATICA—UNUSUAL SUSCEPTIBILITY TO MORPHIA, WITH TOLERANCE OF THE DRUG.

BY WM. G. EGGLESTON, M.A., M.D.,
OF CHICAGO, ILL.

The average length of time, I believe, required for a subcutaneous injection of morphia to take effect as an anodyne is about fifteen minutes; for the hypnotic effect a still longer time is required. The following case is interesting on account of the facts that the drug acted in a remarkably short time, and that at times there was no appreciable interval between the anodyne and hypnotic effects; and on account of the favorable action of quinine in a case of sciatica.

On March 13, at 8 P. M., I was called to see A. F. H., æt. 54, who who was suffering from a severe attack of sciatica on the right side. For sufficient reasons I administered morphia, gr. ⅙, with gr. $\frac{1}{200}$ of atropia. As usual when I administer any drug subcutaneously I noticed the time. While replacing my syringe in the case the patient threw his arms across his chest, said "All right," and was asleep immediately. This was just four minutes after the injection was made. Being somewhat alarmed at such unusual susceptibility, I aroused the patient and spoke to him. I had no difficulty in awakening him, and he seemed surprised that I had aroused him. He said that the drug had had a similar effect two or three years ago when he had taken it, and his wife confirmed his statement. Upon this information I determined to set aside my proposed treatment of the case with injections of ether, and to use morphia, with cod-liver oil and phosphorus internally.

On the next day, March 14, I administered gr ⅙ morphia, with gr. $\frac{1}{200}$ of atropia, at 9 A. M. The patient had slept well the night before until about

3:30 A.M., after which the pain began to return slowly. The injections were made superficially behind the right trochanter on the affected side. Within three minutes the patient announced that he "felt it" in his arms—"a kind of numb feeling down through the elbows." Within another minute he said that he was perfectly easy. This time, however, he did not fall asleep. Another injection was made in the evening, the pain being annoying, but not so great as on the previous afternoon. Within a few seconds less than four minutes he began to say that he felt better, but was asleep before the sentence was completed. In the morning he had commenced taking teaspoonful doses of cod-liver oil and phosphorus (gr. i–f℥jss).

March 15.—Patient said that he had misinformed me as to the element of periodicity in the attacks of pain before I was called in. He now remembered that the first attack, about five days previously, had come on at 8 P.M., the second about 7:30; the third a little earlier, and the attack on the previous day about 5 P.M. I ordered bisulphate of quinine gr. xxx, one-half to be taken at 2 P.M., the remainder at 4 o'clock.

March 16.—The pain did not come on yesterday afternoon, and the patient slept all night. The quinine made him "pretty drunk," he said, and yielding to his very earnest desire I ordered none for this afternoon. The pain came on at 5:30 P.M., and I gave morphia at 7:30. As before, he was at ease and asleep in four minutes. The only subjective sensation was the numb feeling down the arms. There was no nausea whatever, and no itching of the nose. I ordered bisulphate of quinine as before, to be taken at 2 and 4 P.M.

March 18.—No pain yesterday. Quinine continued for to-day. Phosphorus in oil reduced to gr. $\frac{1}{500}$ at a dose.

March 19.—No pain yesterday. Quinine continued for to-day, two doses of gr. x each.

March 24.—There has been no return of pain, and the patient has been at work since March 20. He continues the cod-liver oil and phosphorus (now gr. $\frac{1}{100}$ at a dose), and is taking Fowler's solution, gtt. vj after each meal. His appetite is excellent; bowels perfectly regular. Ordered pil. hydrarg. gr. v to be taken on the first appearance of furred tongue or irregular action of the bowels, and to be followed on the next morning by a Seidlitz powder.

March 29.—He reports that he is still improving, and there has been no pain whatever.

In regard to the use of cod-liver oil in sciatica Anstie has long laid much stress on its importance, as has Dr. Ashburton Thompson. Anstie insists that fat must be liberally taken. So also, in regard to the use of phosphorus, Dr. Thompson has used and recommended it for some time. He gives it in solution in cod-liver oil, gr. j—f℥jss. One drachm of this is given every four hours. The solution is best made by adding the pharmacopœial phosphorated oil to the cod-liver oil. Dr. Thompson has given a table of fifty cases of neuralgia treated by phosphorus, and in several the effects of the drug seem to have been truly remarkable. According to him, if marked results be not seen within three days, it is useless to continue this line of treatment. The above recorded case is the second (of sciatica) in which I have recently used phosphorus, in large doses, with cod-liver oil. I am sure that the first case experienced more direct and immediate relief from ether injections than from the phosphorus, and that the second case was cured by quinine. Still, I believe the oil and phosphorus to be valuable parallel and after-treatment.

The amount of quinine used in this case may be thought by many to be excessive. But I think that, as a rule, larger doses of this antiperiodic are required to prevent the recurrence of a severe neuralgia than of an ordinary "chill." Again, many are in the habit of administering quinine in 5-grain doses, and claim that the effects are just as good or even better. But it is necessary to use 5 or 10 grains more, as a rule, when it is given in this way. A protracted personal experience with "chills" has given me a dislike to small doses of quinine (gr. v every four hours) in intermittent affections. Nor do I think that the value of quinine in neuralgia is limited to the strictly intermittent cases. I recall one case in which a severe case of non-intermittent (though probably malarial) trigeminal neuralgia was effectually routed by two doses of gr. xxx, on two successive days; though the patient had been taking gr. iv three times a day for fully two weeks.

At any rate, it must be admitted, as has been shown, that large doses of quinine, given at one time for the antipyretic effect, have a more marked effect on the temperature than the same quantity distributed over a long time; and I see no reason to doubt that the same holds true when the drug is given solely as an antiperiodic. It is possible, too, that malarial pyrexia and malarial neuralgia differ only in this: in the first the nervous explosion is general, and takes the form of fever; in the second it is localized in one or more nerves and causes pain. One reason that has been advanced against the giving of one or two large doses of quinine is that it is rapidly eliminated. In three experiments Thau found that about three-fourths of the amount given was eliminated in *twelve* hours.[1] I use the bisulphate invariably. It is very much more certain in its effects, much more soluble, and its effects are therefore more quickly produced. Its solubility, moreover, renders it especially adaptable for hypodermatic administration. When thus used the solution should *always be brought to the boiling point* in the spoon immediately before it is taken into the syringe. This, I think, is the most certain way to prevent sore spots and abscesses after subcutaneous injections of any drug.

In regard to the extreme susceptibility to morphia, with the tolerance, without any bad or unpleasant effect whatever, of a dose which acted so quickly, I think that the case recorded is very remarkable. That the imagination of the patient had nothing to do with the rapid effect was shown by the fact that a subcutaneous injection of warm water, given experimentally on the second day, had no effect whatever.

65 Randolph St.

[1] Binz found that about two-thirds only was eliminated in 48 hours, but his results have been questioned.

A CASE OF STRAMONIUM POISONING, WITH PECULIAR SYMPTOMS.

BY C. C. GRATIOT, M.D.,

OF SHULLSBURG, WISCONSIN.

Between the hours of 7 and 8 P.M. on February 22 I was called in haste to see the child of Street Commissioner Thomas Lee, of Shullsburg, the messenger stating that the child was having convulsions. I arrived at the house within a few moments and found the patient, a boy three years of age, sitting in his mother's lap, his arms and hands outstretched as though to grasp some object. He would open and shut his fingers with deliberation, as though the object he was trying to grasp required some caution and skill to take hold of. After two or three minutes of such manœuvreing he would make a sudden jump as though about to seize the object, and would then cry distressfully.

While his hands were thus employed his eyes were fixed, looking straight ahead as though watching something. The pupils were widely dilated, cheeks flushed, mouth dry, pulse fast and full, heart's action good but fast, and respirations increased.

There was also another hallucination. He would act as though something was approaching him from the opposite side of the room, and would point towards it: his eyes and facial expression would convey the idea that the object was after him, and coming nearer and nearer, until he became so agitated that he seemed on the point of having a convulsion.

These hallucinations would alternate, and the only thing that diverted his attention for an instant would be to offer him a cup of water, which he took with a seeming relish. Turning down the light until the room was almost dark made no difference in his actions.

I was told by the parents that he had always been healthy; that he had been playing out of doors all day, ate a hearty supper, and that nothing wrong was noticed until a few moments before they sent for me, when he commenced to act in the manner described. I inquired if there was any medicine in the place that he could have taken, but could find nothing that threw any light on the case. While watching him and making these inquiries I noticed that the symptoms were getting worse.

It occurred to me that the symptoms were those of belladonna poisoning. I administered an emetic of ipecac, gr. x, and a large quantity of water. He vomited in a short time, but there was nothing unusual in the ejected matters. I then gave small doses of morphia and bromide of potassium, and rectal injections to move the bowels, but without effect. After an hour he became more quiet, and fell asleep. After an hour's sleep he seemed somewhat better. The pupils were still widely dilated, but the hallucinations were not so vivid.

On telling a professional friend of the curious actions of the patient he remarked that the symptoms were similar to those which he once saw in the cases of two children who had eaten stramonium; and it immediately occurred to me that such was the case with my patient. He vomited several times during the night, and would wake up and go through his performances; but not so badly as during the evening.

On the morning of February 23 he was much better. The crazy actions had disappeared, but the pupils were still considerably dilated, cheeks flushed, and he was very thirsty. He ate a good breakfast, and before night was apparently as well as ever. In the matters vomited during the night were a number of stramonium seed. I found on inquiry that his father had kept a patch of stramonium plants in the corner of his yard, which he used in making ointment for horses. The boy had cut one of the dry stalks, which was hanging with pods full of seed, and had eaten a quantity of the seed. After finding the cause of the child's sickness the mother remembered his bringing the stalk on the porch, and saying that he had cut a tree.

The case is of still further interest as showing that stramonium poisoning is quite possible in winter if there be any of the dead plants about with pods full of seed.

MEDICAL PROGRESS.

CAUSATION AND NATURE OF HYPERTROPHY OF THE PROSTATE.—MR. REGINALD HARRISON gives an interesting summary of his views on this subject as follows: In a paper recently published[1] on some "Changes in Form of the Prostate and Floor of the Bladder," I have shown that the inter-ureteral bar of muscular fibres so frequently met with in cases of enlarged prostate is to be regarded as the outcome of efforts, by the development of extraordinary agents of micturition, to expel urine from a part where it is apt to lodge and cause inconvenience. In connection with these investigations, I have met with instances where an unusually depressed state of the floor of the bladder, or trigone, appeared to me to have existed previously to an enlarged prostate; in fact, that a condition of residual urine preceded, and was not the sequence, of enlargement of the gland. The trigone, or floor of the bladder, in addition to being a highly sensitive part, is peculiar in that it contains but few muscular fibres in its composition; muscle in abundance may be found as low as a line corresponding with the openings of the ureters, and marking the superior boundary of the trigone, and below in the prostate; between these two points the power of muscular contraction can hardly be said to exist. Assuming that, from any cause, such as long retention of urine, habit, position of the body, or the weakness connected with advancing years, the trigone, or non-contractile part of the bladder, becomes permanently depressed or altered in form, so that the person finds himself unable to get rid of the last half-ounce or so of urine, the effect will be frequently repeatedly expulsive efforts in all the muscles immediately adjacent to a part which, by reason of its connections and structure, has no power of exercising contractility. This will eventually lead, as I have

[1] Liverpool Medico-Chirurgical Journal, July, 1885.

shown, to the hypertrophy of the muscular fibres between the orifices of the ureters—the intra-ureteral bar—as well as, I believe, to that of the muscular fibres so largely entering into the composition of the prostate. In this, I submit, will be found the immediate cause of prostatic hypertrophy. The change being an example of an hypertrophy, its production by conditions favoring the formation of over-growths observed in the body seems to be reasonable. Such a view, as applied to the large prostate, is strengthened by certain clinical observations. A frequent desire to empty the bladder is constantly met with in what is regarded as the earliest stage of prostatic hypertrophy, and long before the gland has assumed any considerable size; the more frequent the calls are to urinate, the more rapidly does the prostate grow, and all circumstances which tend to increase irritability of the bladder may be said to favor the development of this condition. Lastly, the only means which are known to have caused the opposite state—namely, that of atrophy, to be engrafted on the hypertrophied gland—are those which for a considerable time converted a muscular and physiological act into a purely mechanical one; for instance, the case I published[1] some years ago (since repeated with equally satisfactory results), where, by the wearing of a canula inserted through the perineum, the process of micturition was reduced to the mechanical act of turning a tap on the part of the patient. Though regarding senile enlargement of the prostate as an hypertrophic change, I was at a loss to explain how it was induced until I met with instances where, from the conformation of the bladder, an irritating condition of residual urine seems to have preceded, and not to have been the consequence of, an enlarged prostate. Instances in practice are not uncommon in elderly males, where all the symptoms usually assigned to prostatic enlargement are present, without there being evidence, beyond the presence of some residual urine, that any physical change in the gland has taken place.

The frequency with which the floor of the gland is the first to show the hypertrophic change seems to strengthen the inference I have drawn from the development of the inter-ureteral bar, and to indicate that both conditions are the direct result of straining and an excess of the expulsive action of the bladder and associated parts. Structurally, the inter-ureteral bar and the hypertrophied prostate are identical, with the exception that in the latter will be found the follicles which have led to it being regarded as a glandular body. It is impossible to examine some of the commoner forms of advanced prostatic hypertrophy without being struck with their resemblance to what I would describe as growing casts of the interior of a frequently contracting bladder.

But it may be urged that if repeated expulsive action on the part of the bladder causes enlargement of the prostate to follow, how is it that stone and urethral stricture do not in like manner occasion it as a uniform consequence? To this I would reply that stone and stricture as excitants of expulsion are general or varying in their operations, and do not, as a rule, merely involve a limited area of the bladder wall; consequently the hypertrophy following stricture is universal so far as the viscus is concerned. In the same way, the whole bladder is involved when a growing prostate becomes in addition an obstacle to micturition. When a stone is fixed to the bladder it is, I believe, subjected to precisely similar influences on the part of the bladder wall immediately adjacent to it as those described in connection with the trigone, and may result, as I have seen, in a circumferential development of muscular tissue sufficient in some instances to produce sacculation. This is not an uncommon process, and may be studied with advantage in those cases where secondary calculi are developed as a consequence of surface irregularities produced by a large prostate, and which I have referred to elsewhere as fixed or stationary stones.[1] Further, it may be urged that such an explanation cannot be held to cover those instances where persons with more or less enlarged prostates do not suffer from them. I have investigated cases of this kind generally with the result of finding out that, at some period in their history, considerable urinary irritation was present and persistent. That an hypertrophy may prove to be *a precise compensation*, without, on the one hand, falling short, or, on the other, overlapping, I think we have evidence of here as in other parts of the body. It has been objected that enlargement of the prostate cannot be regarded as a mere muscular hypertrophy, as it does not occur during those periods of life which are most remarkable for muscular activity and development. On the other hand, it is hardly necessary to remark that, though an hypertrophic act in which muscular tissue is principally involved, it is really prompted by alterations in the form or function of a contiguous part which are the products of advancing years.

It may not be out of place to observe in connection with analogous processes of hypertrophy, which in general terms have been referred to, that the best marked are those where structural defects are remedied, not in the part itself at fault, but in that which is adjacent. In the heart it is not the valve that is reproduced, but the ventricle or auricle which is augmented. Nor does the analogy cease here, for as the hypertrophied heart in turn occasions symptoms peculiar to itself, in like manner does the large prostate produce its own derangements. In conclusion, it should be remembered that the changes and diseases to which the hypertrophied gland is liable, and about which there is much to be said of great practical value, must not be confounded with the primary lesion it is desired here to refer to.—*Lancet*, March 6, 1886.

[1] British Medical Journal, Dec. 24, 1881, and April 8, 1882.

PYRIDINE IN ASTHMA.—DR. JOSEPH NEFF, of Philadelphia, in an article on this subject, gives the following summary of his results with this drug:

Nervous pulmonary asthma, 3. No return of attacks in any.

Cardiac asthma, 3. All were relieved of attacks. One remained under observation three months, and one for two weeks only.

[1] Annals of Surgery, June 1885.

Bronchial asthma, 3. In one there was no return during ten weeks' stay in the hospital. The two others were relieved of their attacks and insisted upon their discharge, being under treatment less than three weeks.

Asthma in advanced phthisis, 2. In one there was but slight relief during the paroxysm; in the other there was absolutely no benefit.

Asthma as a complication of gout, 1. No return in a month. Albuminuria from interstitial nephritis was present.

Of the fourteen cases reported by Sée, four were in females, ten in males, from 30 to 68 years of age. Nine were what he terms "pure asthma," all of which were more or less relieved, and five cases of cardiac asthma.

In one case of twelve years' duration pyridine caused nausea and vertigo after eight days of treatment, which necessitated its discontinuance, although great relief was obtained. Nausea I have not seen; vertigo but once. In one or two cases where the expectoration had been purulent it lost that character after the inhalation. All unpleasant symptoms seem to be confined to cases with long-standing emphysema, or valvular or degenerative heart disease, with small, irregular pulse. In young, robust people with "simple" pulmonary asthma there seems to be drowsiness alone.

Since these observations were made I have noted, in a more recent report by Lublinski, one case of marked tremor of the limbs with nausea, and another with vomiting, dizziness, and severe headache. In all of these, however, the length of time of each inhalation was prolonged from one to one and one-half hour. The beneficial results obtained from this remedy seem to be from its action on the sympathetic and the medulla. Any depressing effects on the heart would seem due rather to the interference with the pulmonary functions, death being caused, in the lower animals at least, by paralysis of the respiratory centers.

Pyridine is not to be classed as a curative agent. Most likely its greatest value will be seen in cases of simple or nervous pulmonary asthma, when the iodine preparations cannot be borne, or nitro-glycerine and sodium nitrite are contra-indicated. Although in the bronchial or catarrhal forms of the disease the relief of the paroxysms has been marked in ninety per cent. of the cases treated, of the remaining number nearly all had emphysema of long standing. In asthma occurring in advanced phthisis the drug should be given with care on account of the small amount of lung tissue left unaffected, especially where there is a great degree of consolidation with fibroid in duration, when, perchance, the spasm may be relieved, but few air vesicles remain in condition to respond. Here at least morphine will hardly be superseded.

I have used pyridine in several forms of dyspnœa occurring in different diseases without much benefit. In phthisis the recurring dyspnœa and orthopnœa are relieved during the period of inhalation only, returning in a few moments, and at times with increased violence.

With so little experience, this drug must be administered with a certain degree of caution until its action is thoroughly understood, severe or persistent headache, nausea, vomiting, and vertigo acting as danger signals, warning us to proceed with care.—*New York Medical Journal*, March 13, 1886.

DIAGNOSIS OF CANCER OF THE UTERUS.—DR. H. HANDFORD reports the following interesting case:

M. T., aged 24, was admitted into the Nottingham General Hospital under my care on April 7, 1885. Her family-history was good. Menstruation commenced at the age of 12, the flow lasted four days, and recurred every month. She was married at 15; and had had two children, both of whom died before they were 6 month old. Since then, she had had two miscarriages at about the third month; the last five years ago, since which time she had been regular. She first noticed a fœtid vaginal discharge about six weeks before admission, and a little later saw Dr. Truman at the Nottingham General Dispensary, who diagnosed cancer of the womb. She never had any rash on the skin or falling out of the hair, and had no syphilitic eruption. On vaginal examination, the cervix was found indurated, enlarged, ragged, and excavated so as to admit the index-finger for about three-fourths of an inch. The uterus was somewhat restricted in movement, but the fundus was not enlarged. The patient was also seen by Mr. Wright, the senior surgeon, who confirmed the diagnosis of cancer. The examination caused a little hæmorrhage. I removed a small fragment of the growth, which, upon microscopic examination, was found to consist chiefly of large round cells, with a single large nucleus, but no flat or irregularly shaped cells. The tissue was pervaded by the mycelium of a filamentous fungus (one of the hyphomycetes).

The patient left the hospital, and died eighteen weeks later, six month from the first symptoms. No *post-mortem* examination was made.

The diagnosis was between cancer, sarcoma, and syphilis. The ravages of the latter may be very extensive, but are stated to be limited to primary ulcers taking on a phagedænic character. There was no evidence of syphilis in this case. Sarcoma is said almost invariably to take its origin from the lining membrane of the body of the uterus, and not to commence in the cervix. The microscopic examination of the portion removed did not suffice to determine the exact nature of the growth. The fragment was necessarily small, was infiltrated with inflammatory materials, and consisted in large part of vascular granulations. These latter cover the surface of ulcerating new growths, are an important source of the hæmorrhage, and, in many cases, differ very little in structure from healthy granulation-tissue; though, in others, "cell-nests," or other characteristic structures, may be found. For these reasons, I have come to the conclusion, after many trials, that negative results of the microscopic examination of scrapings or small fragments by no means disprove the malignant nature of the growth.—*British Medical Journal*, March 20, 1886.

THE FUNCTIONS OF THE CORPUS STRIATUM.—HERRN BAGINSKY and CURT LEHMANN brought be-

fore the Physiological Society of Berlin, at the meeting on November 13, 1885, the results of their researches on the functions of the corpus striatum. They remark that as these organs lie deeply embedded in the brain they cannot be reached without considerable damage being inflicted on other parts, and they took pains to adopt a method which should minimise this injury. They found the plan which gave the most exact and uniform results was to plunge a fine glass tube into the corpus striatum and place the other extremity of the tube in connection with an exhausting syringe, by which the substance of the corpus striatum could be sucked out. The experiments were made on rabbits. If that part which projects into the ventricle were removed, the phenomena presented were that the fore and hind limbs of the opposite side were extended if the animal were previously in the sitting position. The extremities, and especially the anterior limbs, could easily be placed in anomalous positions, in which they remained till a stronger stimulus was applied. The movement of the extremities offered a certain resistance to the hand of the operator, which was greater than that of the opposite side. No motor defect was observed when the animal ran or made other voluntary movements. The temperature of the body remained normal, or only rose slightly and at a late period. The animal showed great excitability and much tendency to fear upon various sense impressions, making energetic efforts to escape by jumping from side to side. When the brain substance was removed down to the corpus striatum, without injury to that body, the same symptoms were observed, except that the rise of temperature was more common and greater. The authors of the memoir therefore arrive at the conclusion that the functions of the corpora striata do not differ materially from those of the superjacent brain substance. —*Lancet*, March 13, 1886.

Method of Treating Fractured Clavicle.—At the meeting of the Manchester Medical Society, on February 17, Mr. C. E. Richmond demonstrated an easy method of treating this injury. The position adopted was similar to the French one; the palm of the hand of the injured side being laid flat on the chest. The best position for adapting the ends of the fragments was first ascertained by abducting the elbow from or approximating it to the sternum. A piece of broad strapping was passed round both arm and body, to fix it in the required position. A piece of calico, twelve inches broad (more in a big adult), and in length sufficient to go twice round the body, was torn longitudinally, so as to make a four-tailed bandage, leaving about the middle eighteen inches untorn. This centre part was then grooved round the elbow, and the two lengths of the band (a), that lay next the body, were taken one up in front of the chest, over the flat hand, and the other up behind. These were then knotted together behind the sound shoulder, the other ends being meanwhile held out of the way. The other two lengths (b) were taken round the arm and body in front and behind, and also knotted behind and below the sound shoulder. The (a) ends were then brought down, one in front and one behind, and knotted betwixt the fixed elbow and the body, and then cut off short. The (b) ends were then again brought round the body over everything, and finally knotted in the hollow above the fixed elbow. Wadding was then inserted under the knots to prevent them from galling, and the hand against the chest was secured to the length of bandage, passing over it by means of a strip of calico passed round both. The advantages claimed were these: 1. There was no necessity for special apparatus; 2. The arm was fixed in the most favorable position; 3. The fixing was permanent. The method had been used in numerous cases with the best results.—*British Medical Journal*, March 13, 1886.

Unstriated Muscle in the Kidneys.—The presence of a few scattered smooth muscular fibres in the kidneys has been noticed by several observers, and especially by Henle and Eberth; but Dr. Jardet, of Vichy, has, in a short memoir contributed to the *Archives de Physiologie* of February 15, shown that there is a regular system of such fibres. Most of the text-books state that a layer of smooth muscular fibres is present in the pelvis and calyces, the origin of which is referred to the double muscular layer of the walls of the ureter. Henle describes a special muscular annulus, composed of longitudinal and circular fibres around each papilla, lying just beneath the membrana propria. The longitudinal layer ceases at the plane of the floor of the pelvis; the circular layer may be traced some distance into the renal substance. The function of these fibres is to drive the urine forwards from the papilla into the pelvis. Eberth found, in man, a plexus of unstriated muscular fibres with large meshes on the surface of the kidney. Some of these fibres dip into the cortical substance of the kidney. The system of fibres described by Dr. Jardet were first noticed by him in pathological specimens, but were afterwards found to be present in the normal kidney. The situation, when they came clearly into view, was in transverse and verticle sections of the pyramids of Malpighi. They occupied the perivascular conjunctival sheath of the vessels, and never extended far amongst the renal tubuli. The fibres are grouped into small fasciculi, which spring from the pelvis and run parallel to the larger arteries and veins, but do not constitute a complete sheath to any vessel. They become hypertrophied in lithiasis, in hydronephrosis, and in all chronic inflammations of the kidney—*Lancet*, March 13, 1886.

Strychnine in Post-partum Hæmorrhage—In a note on this subject Mr. F. H. V. Grosholz says: Though I have not made any trial of a course of strychnine for pregnant women, to prevent the occurrence of hæmorrhage in labor, I have for the past ten years been constantly in the habit of administering it to arrest *post-partum* hæmorrhage. My favorite combination to produce regular uterine contraction in these cases is a mixture containing fifteen minims of tincture of nux vomica, fifteen minims of tincture of opium, and half a drachm of ammoniated tincture of ergot. I have almost invariably had most satisfactory results with this dose. Nux vomica, through

its alkaloid strychnine, has the direct and almost immediate effect of producing muscular contraction—especially strong in paralyzed parts—and also of retarding the circulation; nor is it improbable that the exaltation of the nervous system produced by its administration renders the action of the ergot more prompt and effectual. The object I had in view in adding the opium was mainly to prevent irregular or spasmodic contraction of the uterus, and also to allay the excitement frequently present in these cases. I have found the preparation of ergot here mentioned particularly reliable, and its stimulant effect is of decided advantage. In abortions and miscarriages, I have also had satisfactory results from the administration of this mixture, given frequently and in smaller doses. In future cases of unknown hæmorrhage tendency, I intend to try the effect of a course of strychnine, and expect that benefit will be derived from this anticipatory treatment.—*British Medical Journal*, March 13, 1886.

BELLADONNA INHALATION IN ACUTE BRONCHITIS.—MR. N. E. DAVIES says in regard to this subject: In acute bronchitis, I believe the dyspnœa is caused more by the contraction of the muscular tissue of the air-cells due to the irritation caused by the bronchial inflammation, than by the viscid mucus secreted; and, acting on this belief in a case I had occasion to treat a few days ago, where the dyspnœa seemed likely to terminate life, I gave a grain of extract of belladonna in half an ounce of water, by means of a Dr. Seigel's inhaler. After the patient had inhaled this solution for a few minutes, the breathing became quiet and easy; and before the half-ounce was exhausted, the patient was asleep. By repeating this remedy every few hours, with a stimulating system of treatment by the mouth, the patient, an old lady aged 75, soon passed the dangerous stage, and is now recovering.

I have often used this method of treatment in asthma with magical effect, and can strongly recommend its trial in the early state of acute bronchitis, as I have found it marvellously successful. It has the advantage of the ordinary bronchitis-kettle, that it moistens the air of the sick-room, and administers a powerful remedy at the same time.—*British Medical Journal*, March 20, 1886.

EXPERIMENTAL AORTIC REGURGITATION.—By lacerating the aortic valves by the aid of instruments passed into the aorta through the carotid artery, M. FRANÇOIS FRANCK has been able to study the immediate and remote effects of this experimental form of aortic regurgitation. In some cases death supervened rapidly, especially when the heart was diseased previously. If the animal survived, the arterial tension, at first lowered, mounts again, and the heart becomes hypertrophied and its vascular activity is increased. According to M. Franck the excessive work of the heart is not to be solely attributed to the aortic reflex, but also to an irritation of the sigmoid region, on the ground that slight lesions or a superficial irritation of this region give rise to a similar hypertrophy. He also explains the danger of syncope of cases of aortic incompetence by the excessive and prolonged distension of the cardiac cavities, as well as by the depression of the arterial tension of the brain.—*Lancet*, March 6, 1886.

THE DIGESTION OF MILK.—DR. M. REICHMANN draws the following conclusions from a number of elaborate experiments as to the digestibility of milk in the human stomach (*Deutsche Med. Zeitung*, No. 82, 1885):

1. Boiled milk leaves the healthy stomach more rapidly than an equal quantity of unboiled milk.
2. The digestion of boiled milk is more rapidly accomplished than that of unboiled milk.
3. The coagulation of unboiled milk in the stomach is complete in five minutes.
4. The coagulation is not caused by the acid of the gastric juice, but by the influence of a special ferment (milk-curdling ferment).
5. The acidity of the gastric juice is at first due almost solely to lactic acid, and, later in the process of digestion, to the presence of hydrochloric acid.
6. Hydrochloric acid first appears in perceptible amount forty-five minutes after the ingestion of half a pint of milk.
7. For the first hour and a quarter after the ingestion of milk the acidity gradually increases, and then decreases, until the milk has entirely left the stomach.
8. The curds of casein in digestion of boiled milk are much softer than in the case of uncooked milk.—*Therapeutic Gazette*, March 15, 1886.

THE URINE IN PUERPERAL ECLAMPSIA.—M. DOLERIS has found that some specimens of the urine of patients with puerperal eclampsia give, on drying, crystals whose composition is at present undetermined, but which are slightly soluble in alcohol and soluble in acidulated water, and a somewhat concentrated solution of which injected into animals killed a rat and three sparrows, while comparative experiments made with a portion of solution containing no crystals produced no effect. M. Doleris found a normal amount of urea in the blood of two patients dead of the disease, but an increased amount in that of two others who were cured. In one case only were soluble and toxic ptomaines met with. He believes that puerperal eclampsia is of an infectious nature, for it is not only the kidney which is affected but other organs, the liver in particular presenting characters more or less allied to those noted in acute yellow atrophy.—*Lancet*, March 13, 1886.

BORACIC ACID IN DIABETES MELLITUS.—MR. F. A. MONCKTON reports in the *Australasian Gazette* (October, 1885) a case of a boy, aged 14, suffering from diabetes mellitus, with all the symptoms in an aggravated form, who was apparently cured by the use of boracic acid in 7-grain doses three times daily. At first there were no stringent dietary regulations, and even in the later part of the treatment only sugar, potatoes, and oatmeal were forbidden. Bread was eaten at the meals in the ordinary way. He gradually gained in weight, his health improved, and the sugar disappeared from the urine.—*Therapeutic Gazette*, January 15, 1886.

THE
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PUBLISHED WEEKLY.

THE EDITOR OF THIS JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

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DIAPHRAGMATIC PLEURISY.

In the *American Journal of the Medical Sciences*, for April, 1886, DR. FRANK DONALDSON, JR., of Baltimore, gives a most interesting study of this rare affection. As is often the case when we come to look up the literature of some medical subject, we find that this affection was very accurately described by Galen, at least in so far as the peculiar character of the respiration and the retraction of the hypochondriac region are concerned; though he supposed that the seat of the affection was in the muscular structure and not in the serous covering. The disease was mentioned by several writers in the seventeenth and eighteenth centuries, but in an obscure manner, and it remained for Andral to publish, in 1823, the first definite observations of the affection, under its proper name diaphragmatic pleurisy. His paper was published in the *Archives de Médecine*, and in the following year, in his "Clinique Médicale," he gives a record of five cases. Thirty years after the appearance of Andral's paper Guéneau de Mussy published an elaborate monograph on the subject, in the same journal in which Andral's first paper had appeared.

Dr. Donaldson's case, on which his paper is based, was that of a man of about 40 years of age. He had been sick for nine weeks, the illness having begun with a chill, "followed by an intense pain referred to the lower intercostal region, more particularly on the right side, with great and increasing difficulty of respiration. He had been, almost from the first, unable to lie down, sitting always with the body bent forward, and his hands pressed to the side to prevent any extra motion." There was an incessant dry cough, with dyspnœa and anxiety of countenance. The abdomen was retracted, the diaphragm almost immobile, and the respiration almost entirely costal. There was some dulness around the lower part of the chest, especially posteriorly on the right side. Pleural friction sounds were heard only on the left side. On the right side the inflammation had extended to the lung structure and set up a localized pneumonia. Anteriorly and posteriorly were points painful on pressure. The diagnosis was diaphragmatic pleurisy of tubercular origin, with slight effusion on the right side. The patient rapidly grew worse, the pneumonia was not resolved, and the lung began to break down. The patient died, but the record does not state at what time after the commencement of the disease.

Besides the serious and more rare forms of diaphragmatic pleurisy, there is a form called acute benign, first written of by Bucquoy, in his "Leçons Cliniques" in 1873. It always tends to recovery, and seems to be a distinct form of diaphragmatic pleurisy. Hermil, Bouchut, Monod, Robert and Fiessinger agree with Bucquoy, and report respectively (except Hermil) 3, 1, 1, and 9 cases, all ending in recovery. Its onset, with chill, pain in the side, and fever, is similar to ordinary pleurisy, but the painful spots and radiating pains, with tender and retracted abdomen, show that the diaphragmatic pleura is affected. It is unilateral until the third day, and then extends to the opposite side; though the invasion of the second side is not accompanied by great pain, and all the symptoms are less severe than when the first side is affected. It is a rather singular fact that the pleurisy disappears first from the second side, and the extension of the inflammation seems to lessen the symptoms. The effusion rises to a higher level on the second side, though the symptoms are here less marked. On the first side there is usually some retraction of the base of the lung on account of the fluid between it and the diaphragm. On account of the retractility of the lung, and the drawing up of the fluid with it, there may be signs of extensive pleuritic effusion, and an erroneous diagnosis is possible. This effusion usually disappears without surgical interference, and the cases result in cure within two or four weeks.

Andral, de Mussy and others think that diaphragmatic pleurisy is not so uncommon as is generally supposed. The number of cases on record is somewhat less than one hundred, but the apparent rarity may be due to errors in diagnosis and failure to record cases when seen. Though the onset is variable, the affection is usually ushered in by a chill of greater or

less violence, followed by fever and sweating. When secondary pleurisy occurs in the course of acute or chronic disease it is marked by an increase in the fever, or a second chill; but the pain and other characteristic symptoms attract attention chiefly. "Intense pain in the side and constriction of the lower part of the chest, soon follow the chill. The pains of diaphragmatic pleurisy are characteristic, and are to be referred to the terminal filaments of the phrenic nerve;" what Hermil calls *douleurs par propagation.* Many of the peculiar symptoms found in connection with the affection are explained by a reference to the anatomy and distribution of the phrenic nerve. The pains extend over a large surface—"over the whole hypochondriac region and over both flanks to the inferior dorsal region behind, following the line of the costal insertions of the diaphragm, and often along the border of the sternum and under the lower insertion of the sterno-cleido-mastoid muscle, and over the shoulder and neck." They may be spontaneous, but are always provoked by pressure, increased respiratory movements, hiccough, vomiting, etc. The favorite seats of pain, according to de Mussy, are over the epigastrium, at the points of insertion of the diaphragm; in the eleventh interspace behind, near the spine; along the course of the phrenic nerve; and at the *bouton diaphragmatique*, a point one or two fingers'-breadth from the middle line, on a level with the tenth rib, or at the intersection of a line drawn from the osseous part of the tenth rib and one drawn along the border of the sternum. The pain is always very great at this point, and is due, according to him, to the greater play of the rib, and the consequent friction against the inflamed nerve. The pain along the course of the phrenic nerve is rarely spontaneous, but is always evoked by pressure, especially where the nerve runs under the sterno-mastoid muscle.

The *douleurs par propagation* run along the sides as far as the iliac fossæ in some cases, though they are usually more intense in upper part of the body; and are sometimes felt with great intensity in the muscles having nervous connections with the cervical and brachial plexuses. As regards the pain felt over the liver and spleen it is difficult to say whether it is due to pressure of those organs on the inflamed muscle, as Dr. Donaldson thinks, or to a local peritonitis from extension of inflammation. Pain is more often present in the hypochondriac region than in any other locality in this affection. The attitude of a person suffering with this disease is very characteristic, and is well shown in the case recorded. The symptoms which are most distinctive and prominent are the frequency and shallowness of the respirations; respiration is entirely costal, and confined to the upper part of the chest; and in a case reported by de Mussy it was unilateral. The number of respirations is enormously increased, Hayden and Graves reporting cases in which the number was 80 or 100. When effusion takes place in diaphragmatic pleurisy there is, according to Chaffaud and de Mussy, a lowering of the twelfth rib, its anterior end being lower than that of its fellow on the opposite side. Hiccough, nausea and vomiting are often present, as might be supposed. Delirium, which at one time was supposed to be diagnostic, is thought by de Mussy to be more frequent than in costo-pulmonary pleurisy. The affection is to be diagnosticated from rheumatism of the diaphragm, inflammation of the muscular structure and neuralgia of the diaphragm, costo-parietal pleurisy, pericarditis, hepatitis, and circumscribed peritonitis; but it seems that proper care should prevent any error in diagnosis unless the disease be complicated with some one of these affections.

CHRONIC TEA-POISONING.

At various times during the past few years medical men, chiefly in England, have called attention to the deleterious effects of tea upon those who partake too freely of this beverage. But though some attention has been called to the subject very little has been written that is at all definite, in the way of substantiating assertions by clinical proof. The paper on "Chronic Tea-Poisoning" read by DR. WILLIAM N. BULLARD before the Suffolk District Medical Society on March 10, in which he gives a record of five cases may therefore be regarded as a valuable contribution to a comparatively obscure subject.

In his paper Dr. Bullard deals only with cases of subacute and chronic tea-poisoning, leaving out of account all acute cases and those of professional tea-tasters. These have already been fully written of by Morton, in a paper on tea-tasters, based on five cases, in which he gives the symptoms of "continued and immoderate use of tea" as headache, ringing in the ears, tremulousness, nervousness, exhaustion of mind and body, with disinclination to mental and physical exertion, increased and irregular action of the heart, and dyspepsia. It will be seen that these symptoms correspond very closely to those of chronic tea-poisoning. Dr. Bullard's statistics are based on 163 cases of tea-drinkers, and he also examined, for the purpose of differentation, 158 cases in which symptoms of tea-poisoning occurred, but in which he was not inclined to attribute the symptoms to the abuse of tea. In analyzing his cases he follows the order of symp-

toms given by Morton, and considers the frequency of the different symptoms, in order to see what combination of these may be considered as characteristic of tea-poisoning. Headache occurred in 30 per cent. of the cases, hemicrania in 11 per cent. In the cases in which the headache was bilateral it was situated generally in the forehead and temples. "Ringing in the ears" was not frequent. It was noted in but three cases, in two of which it was due to disease of the ear, while in the third case it accompanied a congestive headache supposed to have been due to exposure to a hot sun.

We may very properly classify four of the symptoms under the general head of nervous phenomena. Tremulous, according to Dr. Bullard, is not uncommon, and it probably occurred in many cases in which its existence was not noticed or specified. In other cases it was probably given as "nervousness." Tremor was noted in six cases, "but in only one of these does is seem fairly attributable to the tea;" and he concludes that tremor is not an ordinary symptom of chronic tea-poisoning. "Nervousness" was prominently noticeable in 16 per cent. of the cases, its total absence in one case. "Slight degrees of nervousness probably exist in nearly all these patients, but we cannot therefore conclude that it is the direct result of tea." In many cases it is doubtless due to the digestive troubles. As regards the symptom "exhaustion of mind and body, with disinclination to physical exertion," Dr. Bullard says that it "is of too indefinite a character to be susceptible of accurate determination in the class of cases with which we have to deal. Moreover, its liability to occur from other causes renders it impossible to determine how far it is due to tea." We have noticed this symptom prominently in tea-tasters, however. In the cases examined general weakness was mentioned in 8 per cent. Increased and irregular action of the heart does not appear to be a necessary symptom of chronic tea-poisoning. Palpitation, which was present in almost all severe cases, occurred in 49 per cent., and irregularity of the heart in six additional cases.

The symptom dyspepsia in those who use tea immoderately seems to have been more frequently noticed than any other by foreign writers, and Dr. Bullard says that "the occurrence of gastric or intestinal symptoms with chronic tea-poisoning is almost universal;" but that in many cases these do not assume a very prominent form. He has noted those cases only in which there was "a distinct sense of oppression or fulness in the epigastrium after eating." Of these there were seventy-five cases, or 46 per cent. Pain in the epigastrium occurred in 9 per cent. Vomiting occurred in 17 per cent. (twenty-eight cases), and nausea in 20 per cent. In thirteen cases the vomiting was combined with nausea; in twenty-two cases it was noted under dyspepsia. Nausea was reported alone in five cases, in three of which it occurred with headaches, in one there was trigeminal neuralgia, and in one it was probably due to the use of tobacco. Pain in the left side, or in the cardiac region, which is a frequent symptom in women, and probably due generally to the gastric condition, occurred in 21 per cent. of the cases. It is surprising to note that serious intestinal disturbances, and especially constipation, do not, according to Dr. Bullard's account, occur very frequently in the cases under consideration. Loss of appetite occurs in a greater percentage of cases (61 per cent.) than any other symptom. Dyspnœa was present in twenty-three cases, "but seems usually to be secondary to anæmia or cardiac weakness." In two cases it was due to pulmonary disease, and in nineteen was accompanied by palpitation. It is somewhat surprising that anæmia was present in only 18 per cent. of the cases. We may therefore put the comparative frequency of symptoms in chronic tea-poisoning as follows: anorexia 61 per cent; dyspepsia and pain in the epigastrium 52; palpitation 49; constipation 47; nervous symptoms 42; headache 30; pain in left side 21; nausea 20; vomiting 17. "All these symptoms are common in many other diseases, but it is the special combination which exists here, and above all the predominance of the nervous group, which enables us to form our diagnosis. It is evident that there exists many cases of this affection in which no diagnosis could be arrived at from the symptoms alone without the history, but I firmly believe that in the majority of the cases, a presumption in favor of this affection is justifiable from the sole evidence of the symptoms."

The first evidence of chronic tea-poisoning is a gradually increasing difficulty of digestion, followed by general restlessness and excitability of the nervous system, by disinclination for food and headaches. Constipation is present in almost one-half the cases. "Palpitation, which has previously been slight, now becomes distressing, and is not infrequently accompanied by dyspnœa." Up to this point the patient may declare that her health is good; but in the more severe cases the symptoms now become more pronounced, and usually point to digestive troubles or hysteria, or both. "Whenever a marked gastralgia exists without evidence of organic disease, wherever we find frequent vomiting apparently unaffected by food and unaccompanied by gastric catarrh; in other

words, wherever we find evidence of a true gastro-neurosis, or if increased excitability of the gastric nerves greater than could ordinarily be accounted for by by the condition of the stomach, whether dyspepsia be present or not, if the agency of alcohol can be eliminated, we should always suspect tea-poisoning. . . . . We have at present no evidence in regard to the condition of the blood-vessels in this affection and it is reasonable to suppose that no great variation from the normal will be found, inasmuch as the trouble is so chronic and in many cases so slight. Whether or not any increase exists in the excitability of the vaso-motor nerves under these conditions would be an interesting subject for investigation. . . . It is of special importance to remark that the affections of the nervous system due to chronic tea-poisoning are, so far as my observation show, *always functional.* Where organic symptoms exist they are not connected with tea.

The average amount of tea taken by those who showed symptoms of poisoning was 4.8 cups *per diem.* This, however, cannot be taken as a standard for making a diagnosis in any given case. The age and physical condition of the patient are very important considerations. Youth, weakness of any kind, and anæmia, naturally render the system more susceptible to any toxic influence; "and hence we find that even those adults who have for years been accustomed to take a moderate amount of tea without evil effects, if for any reason they become anæmic, if their strength be exhausted by excessive work or in other ways, immediately begin to show toxic symptoms, although the amount of tea ingested has not increased. This is well shown in cases of chlorosis and is very common among factory-operatives and seamstresses. We desire to lay special stress on this fact, which is one cause of the non-recognition of the toxic agency of tea by the patient. That deprivation of fresh air and want of sufficient food should cause the same result is only to be expected, not only because in themselves they tend directly to produce weakness and anæmia, but also because the toxic products are not so readily eliminated. It is for the same reason that more tea can be drunk without evil effect by persons when working or taking exercise than could be taken by the same person when idle or at rest."

PROPOSED NATIONAL BUREAU OF PUBLIC HEALTH.

Under this head in another department of THE JOURNAL will be found a copy of the Bill recently introduced into the House of Representatives by Dr. Robert T. Davis, member from Massachusetts, "to prevent the introduction of contagious and infectious diseases, and to establish a Bureau of Public Health," which was referred to the Committee on Commerce, subsequently reported by the Committee with some amendments, which are included in the present copy, and it was referred to the Committee of the whole House on the State of the Union.

It will be seen that the Bill simply provides for the establishment in the Department of the Interior of a Bureau of Public Health, under the management of a Commissioner of Health with an annual salary of $4,500; with all the necessary powers and duties to secure the establishment of an efficient and permanent National Bureau of Public Health, to take the place of the old National Board of Health, and relieve the Marine Hospital Service from further duties in that direction.

The provisions of the Bill are simple and not likely to bring the Bureau in collision with the State Boards of Health or sanitary regulations, and yet the powers conferred are sufficient for the establishment and maintenance of all such necessary measures as are calculated to prevent the importation of contagions and infections either by persons or goods; for the collection and publication of information concerning the prevalence of epidemic and infectious diseases in all foreign countries with which we have commercial relations; and for prosecuting of original scientific investigations concerning the nature, origin, and prevention of contagious and epidemic diseases both in the United States and in foreign countries. The Commissioner is also authorized to employ such assistants, clerks and scientific experts as may be necessary, with the consent of the Secretary of the Interior.

The introduction of this Bill is the first move we have seen relating to health or sanitary regulations by the general government, which was in the right direction and founded on correct principles. All propositions hitherto made to establish National Boards of Health consisting of several members, representing different sections of the country and somewhat different interests, have two radical defects. First, they are too cumbrous, it being necessary that their most important duties should be performed while in session; and second, they inevitably contain more or less elements of discord. A permanent government Bureau under an intelligent Commissioner, with all necessary assistants, avoids both these evils and affords the best prospect for promptness and efficiency of action. We hope, therefore, that the Bill will speedily pass both Houses of Congress and become a law.

IMPORTANT NOTICE.

We have received from the Treasurer of the American Medical Association, the names of one hundred and fifty-three members of the Association who have not paid their annual membership dues since 1883. Consequently their names have been suspended from the mail list of THE JOURNAL, and will remain so until we are notified by the Treasurer that their dues have been paid. Any of them who choose to pay their arrearages to the Treasurer before June 30th, when the current volume closes, can have their files completed. We have also received, from the same officer, the names of two hundred and one members who have not paid their dues for the current year, now nearing its close. All members who attend the annual meetings of the Association are required to pay the membership fee in advance, before they can take a seat in the meeting, and it is manifestly unfair for those who do not attend the meetings to neglect the payment of their annual fees until the end of the year, or longer, and still be receiving THE JOURNAL the same as those who pay promptly. As many of those who are still indebted for the current year may pay up at the coming meeting at St. Louis, we have thought best not to suspend their names from our mail list until after that meeting. But the Association should adopt a rule, or by-law, making all annual dues from members payable before the 1st of July of each year, and in default, their names to be liable to suspension from the mail list of THE JOURNAL.

INJUSTICE TO DR. FANCOURT BARNES.

In the April, 1886, number of the *American Journal of the Medical Sciences* is a review of the "System of Obstetric Medicine and Surgery" by Drs. Robert and Fancourt Barnes. The writer of the review says, page 522: "Unfortunately, there is a little matter relating to the publication by Fancourt Barnes of a German Medical Dictionary, which does not dispose the profession of this country kindly toward him. That this little volume, published as his, was boldly copied from one the production of an American physician, is only too evident from the fact that the very errors of the one duly appear in the other." The reviewer gives the name of the American physician as George R. Cut*l*er instead of Cutter! From this it seems that the reviewer is not familiar with Dr. Cutter's book. Dr. Cutter's Dictionary contains about 13,000 words, and that of Dr. Barnes about 22,000; from which it seems that he is not familiar with Barnes's book! How a book can be "boldly copied" from one only a little more than half as large does not appear. All of the errors in Dr. Cutter's Dictionary do not appear in Barnes's Dictionary; very many were corrected. But the fact that the two books contain the *same* errors in many places proves nothing. Dunglison's Medical Dictionary contains an error that is to be found in Cotgrave's French and and English Dictionary, published in 1660; and our large unabridged dictionaries contain propagated errors sufficient to convict the authors of plagiarism from any one of half a dozen lexicographers, if this be sufficient evidence for conviction. Of these we need only cite Richardson's Dictionary, Todd's Johnson, Webster and Worcester. As a matter of fact, too, Barnes's Dictionary contains errors in words that are not in Cutter's Dictionary at all, and other errors in words that are correctly given in Cutter.

Great injustice in regard to this matter has been done Dr. Barnes in this country, as this same fable was put in circulation when his book first appeared. We can give the names of several German students, prominent physicians in this country, who believed it and would not get the book. Some had never even seen it until their attention was called to it, but they knew the story; though it is far superior to Dr. Cutter's Dictionary. An importing firm in the East brought over a lot of about 500, and had sold a few when they received a note containing this charge. They bought up the few copies that had been sold, so far as they could, and shipped the whole lot back to England without even making an investigation. We have no quarrel with anyone in this matter, but make this statement in simple justice to one who is not in this country to defend himself. E.

SOCIETY PROCEEDINGS.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, March 4th, 1886.

THE PRESIDENT, B. F. BAER, M.D., IN THE CHAIR.

MENSTRUAL EPILEPSY.

DR. HOWARD A. KELLY exhibited recent specimens of tubal and ovarian disease, removed within the past two weeks. The first specimens to which he called attention were removed from a patient 21 years of age who has suffered from an aggravated menstrual epilepsy from the very first appearance of the function. There was no difficulty whatever in the removal through a small incision into which two fingers could just be slipped. The whole operation, from beginning to complete closure, took but twenty-four minutes. The right ovary was deformed by a very prominent nodule, about one and a half centimetres

in diameter, which burst on removal, discharging a watery fluid, and was shown by its lining membrane to be the last corpus luteum.

The second specimens were rare examples of *Hydrosalpinx, with Congenital Deficiency of Tubes and Broad Ligaments.* In this case there was malformation of the distal ends of the tubes, broad ligaments and ovaries. The left tube is as large as a bologna sausage. It was brought into view with great difficulty after separating many light adhesions to the pelvic walls; while the isthmus is much enlarged and thickened, the great distension is at the involuted ampulla. The operator was materially assisted in bringing this tube into view by upward pressure on the cervix by a hand in the vagina. The fimbriated extremities were lost in a mass of vascular and fibrous tissue forming a broad ligament, and deep down in this were imbedded the somewhat hard, elongated, large ovaries. It was utterly out of the question to attempt a removal of the ovaries, and any such operation would have been of a very desperate character, nor did he, Dr. Kelly, regret this in the least, as he had planned his operation for *tubal* disease, to which he attributed all the patient's sufferings. The right tube was as large as his middle finger and was also distended with watery fluid.

The other specimen was a very large *Hæmato-Salpinx.* This tube, the left, about four inches long, burst as he was removing it, discharging four ounces of tarry blood. It was very adherent, having several attachments to intestine and omentum. The dilatation is here, too, seen to be at the ampulla, which extended far beyond the ovary back into the cul-de-sac. The ovary is embraced by the isthmus, and presents a curious appearance as it lies, about twice the normal size, imbedded in a sort of ball and socket manner below the isthmus. Where it is laid open the tube is converted into one large sac.

DR. JOSEPH PRICE remarked that the tube was so large that the uterus had been pushed aside by it. Great care was required in its removal.

DR. CHAS. HERMAN THOMAS said that some time since he should not have recognized such a condition, but now he can; the result of experience in bimanual examination. He would like to hear further on this point of diagnosis.

DR. B. F. BAER thought it very unfortunate that the ovaries as well as the tubes could not have been removed in the case just reported by Dr. Kelly, for their presence will probably result in the usual monthly congestion, and consequently the pain and other pelvic distress for the relief of which the operation was performed, may continue to exist. There are several cases on record in which the tubes were removed and the ovaries allowed to remain, but the results have not been reported. He could see no reason why this should be done unless the ovaries cannot be found, or some other insurmountable difficulty presents itself. He fully believes in the advantages of prolonged and thorough palliative treatment in these cases. Benefit usually follows, and sometimes cure; at least operation is rendered less difficult and more likely to be followed by recovery of the patient, both from the operation itself and the symptoms. Certainly the application of remedies such as iodine to the fundus of the vagina and the interior of the uterus, with prolonged rest and general building up of the system, will have a strong influence in attenuating adhesions, promoting absorption of lymph and possibly, if not probably, in cure of the patient without operation.

It should not not be forgotten that removal of the tubes and ovaries in these cases does not cure absolutely in every case. He believes that we will be called upon in a few years by many of these cases which have been operated upon to relieve symptoms which still exist or have returned, and for the relief of which operation had been performed; just as we have been called upon from time to time and pestered by those old cases of chronic hypertrophy and retroflexion of the uterus with pelvic adhesions. He has now under his care one of his own cases upon which he operated for the relief of symptoms, the result of disease of the tubes and ovaries with pelvic adhesions. The patient made a good recovery and appeared to have been cured, but the symptoms have returned, and she is now complaining almost as much as before the operation. She also has periodical attacks of metrorrhagia. This, of course, is an unusual case. He has another patient under his care, who was operated upon in a neighboring city by removal of the tubes and ovaries, and is treating her for the same symptoms of which she had complained before the operation. He is an advocate of the operation in some cases, but he pleads for due deliberation and the exhaustion of careful palliative and preparatory measures before operation is resorted to. Many cases will get well without operation. Some will not be benefited if operation is performed, and there is some danger in laparotomy, although Tait has had such remarkable success.

DR. DA COSTA inquired if Dr. Kelly had tried the benefits of rest and treatment before operating?

DR. JOSEPH PRICE said that the recurrence of symptoms seemed to indicate partial removal of the tubes and ovaries. One of the fundamental rules of surgery is to seek for pus when it is probably present and in all cases to remove it if possible. When the ligatures will cut through the tubal stump on account of its cheesy character, hæmorrhage may be prevented by the application of the cautery.

DR. KELLY, in closing the discussion, said he did not in the least regret that the ovaries could not be removed, as he had operated for tubal disease, not for ovarian, and he admired the zeal of Schroeder, who, instead of always removing the ovary, sometimes resected diseased portions. In all the cases of tubal and ovarian disease upon which he had operated, months and years of careful treatment had been wasted, and now, where he diagnosticated pyosalpinx, the only delay he allowed was to put the patient in the best possible condition for operation. Topical, external and internal, treatment is utterly futile, and never does more than secure temporary palliation.

Dr. Kelly's reliance regarding diagnosis lay entirely in a skilled bimanual examination, by which he always accurately mapped out all the peculiarities of the case before operation. If there is rigidity and resistance

it is necessary to etherize, but he has yet to see the case where the presumptive signs were those of tubal and lesser ovarian disease, where the structures could not be picked up between the two hands and outlined. He considers that this tact has been largely developed by persistently examining the condition of the appendages to the utmost possible extent as a routine practice in all cases which come under his notice. Introducing the finger as high as possible, by forcing the hand well under the pubic arch, and carrying the sensitive pulp up against the post-fornix or either lateral fornix, and then playing up and down with the other hand pressing on the abdomen and creeping a quarter inch at a time, without ever fully relaxing, and letting structures in between roll through the two fingers, and in case of an ovary, running round its whole periphery, or of a tube tracing it up to the cornu-uteri and down into the retro-uterine pouch, where it generally terminates, give often most surprising results, and would doubtless, if fully carried out, change hundreds of diagnoses of leucorrhœa, endometritis and flexions with adhesions, to the far more serious ones of pyo- or hæmato-salpinx.

Dr. Joseph Price exhibited some

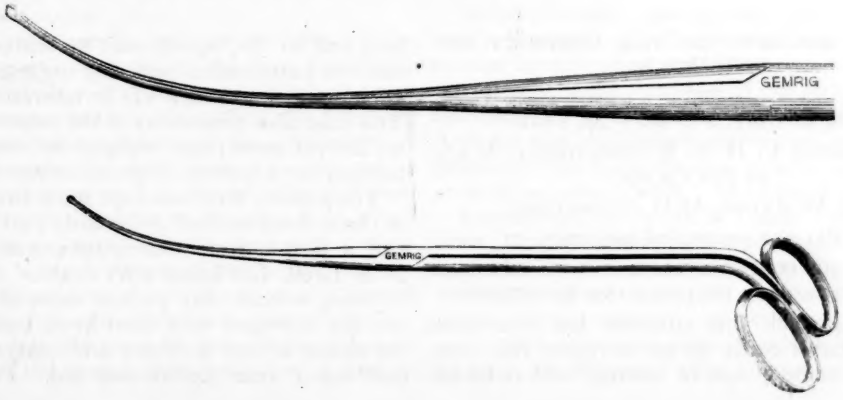
SPECIMENS OF PYO-SALPINX.

from two patients, and afterwards remarked that Tait and Keith have ended the dark period by showing us how to operate on the abdomen and pelvis without fear and with little risk. The wonderful advance in pelvic and abdominal surgery should be placed to their credit. He believes it is now universally admitted that they have reached the very acme of perfection. One surely must be a convert to Tait's law to contend with the great difficulties in pelvic surgery: "That in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made." Standard works on ovariotomy dwell at great length on the subject of adhesions as the most important and difficult complication with which the operator has to contend. In short, in pelvic operations the risk and the difficulty will ever lie in the separation of organized inflammatory products. Adhesions, when old, between the pelvic viscera and diseased tubes, become degenerate and hence easily ruptured. In one case only have strong adhesions, deep in the pelvis, stayed his hand. The right tube and ovary adhered strongly to the sac and right side of the uterus, and the whole adherent mass was absolutely inseparable. Again, the rupture of pus tubes or cysts filled with inflammatory, septic or malignant elements, will be followed by serious symptoms. Operation becomes difficult when the ovaries and tubes, tightly distended with pus, and softened through pathological changes, cheesy in consistence, are matted together with the rectum and small intestines.

Dr. Charles Hermon Thomas exhibited a

UTERINE APPLICATOR AND DRESSING-FORCEPS COMBINED.

This instrument, which is is specially adapted to making applications within the cavities of the neck and body of the uterus, but which is also available for making dressings and applications to the vagina and external surface of the cervix, has borne the test of two years' use. It is in forceps form, the blades are strong and resistent from the handles forward about two-thirds of their length, when they narrow rapidly, so that taken together they become about equal in size to the ordinary uterine sound. This narrow portion, somewhat suggestive of the long beak of the angular ear forceps, is about three and a half inches in length, the tips being roughened on their opposed surfaces. It holds securely the smallest pledget of cotton, and by reason of the springy character of the beak will permit the locking of the handles when a full-sized pledget or tampon is placed within its grasp. The point is slightly probed as an extra precaution when introduced to the uterine fundus, though a small cotton ball answers all needful purposes as a protective tip. I have usually employed the plain point on account of its occupying less space at the internal os uteri. The beak is curved to a shape corresponding very closely to that of Ellinger's dilator, and which has been found so generally well adapted to entering the uterus. This portion is electro-plated with gold, when so ordered (a proceeding of moderate cost and to be commended), as a protective against the corrosive action of iodine, iodized phenol, and the like, which so rapidly destroy nickel-plating and corrode polpolished steel surfaces. The instrument was made under Dr. Thomas's directions by J. H. Gemrig & Son, of Philadelphia.



Some practical points of use may be mentioned: Soiled or medicated cotton is easily removed with the use of one hand only by simply unlocking the handles and wiping the point in a crumpled paper, thus leaving the other hand free for other employment, and avoiding the trouble, the soiling of the fingers, and the whittling often involved when the wire applicator is used. In its use there is immunity from the rasp action of the closely wrapped cotton of the wire applicator, and also a greatly increased carrying capacity of the cotton for medicated liquid. Moreover, it will be found convenient and desirable to make use of the instrument as a uterine sound incidentally in certain instances. In my own experience it has proved practicable as an applicator, one fully meeting the needs of most cases; while as a uterine dressing forceps for general use it has been found so satisfactory as to have superseded all other instruments of this class.

DR. BAER said the instrument presented by Dr. Thomas is a very ingenious one, and will doubtless serve a good purpose where the cervical canal is patulous; a greater quantity of the medicating agent used can be carried to the diseased surface than when the tightly wrapped cotton is used.

DR. J. F. WILSON has nothing to add to what Dr. Thomas has said. He has used one for several months and can agree with Dr. Thomas as to the ease of application and removal of soiled cotton.

DR. PARISH said that the forceps was valuable and would be much used. As an applicator it will be very convenient. A few years ago the sound and applications were too much used, but extremes either way are wrong. Applications to the endometrium are sometimes needed.

DR. H. A. KELLY said this is a very valuable instrument.

DR. PARISH exhibited a specimen of

OVARIAN TUMOR,

removed the previous day. The symptoms had been very peculiar and the form of the abdomen was misleading, there being a deep groove across the hypogastric portion of the tumor. Numerous adhesions gave great fixity. These adhesions embraced the colon, parietes and bladder, and were old and dense. Its rapid growth had raised a question of malignancy. A great portion of the tumor was solid.

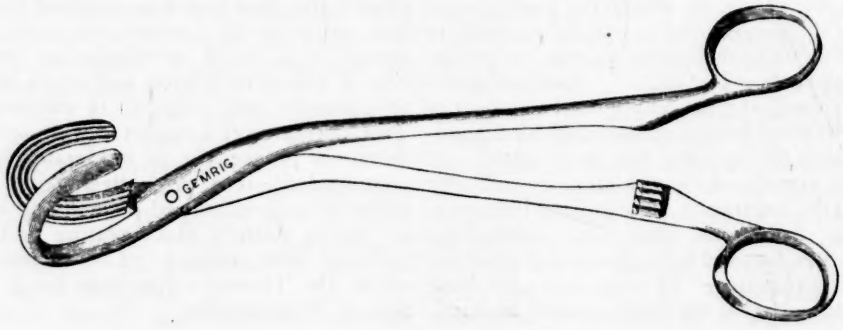
DR. HARRIS remarked that a microscopic examination of the tumor should be made. There had been great difficulty in diagnosis as to the origin and character of the tumor. A slight fluctuation could be detected in the lower portion under the use of an anæsthetic. There had been no uterine symptoms, and menstruation had been regular The long fallopian tube crossed the tumor and made a deep constriction across its middle.

DR. BAER did not think rapid growth a proof of malignancy. He had seen five or six cases of very rapid development; one in three months contained a bucketful of fluid. In none of these cases had there been any return or other sign of malignancy. The presence of papillomatous growths within the cyst is no proof of malignancy.

DR. JOSEPH PRICE exhibited a

FORCEPS

for the complete closure of the trocar puncture in ovariotomy.



MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Stated Meeting, February 24, 1886.

THE PRESIDENT, C. H. A. KLEINSCHMIDT, M.D., IN THE CHAIR.

T. E. MCARDLE, M.D., SECRETARY.

DR. G. S. PALMER presented specimens of

ABSCESS OF THE CORPUS STRIATUM; AND ADHESION BETWEEN THE GALL BLADDER AND THE COLON.

The case to which your attention has been called by the Secretary's cards for me to report this evening, presents some points of interest both in its history and in the appearance presented by the post-mortem examination, and may suggest questions and elicit discussions which will be interesting and useful. This case also reminds us of the humiliating fact that we are yet sometimes obliged to depend upon an autopsy for a correct diagnosis of our case.

The patient, Mrs. ——, age 66, married and mother of three children, died in the early part of this month, and a post-mortem examination was made by Dr. D. S. Lamb five hours after death. As a child and a young woman this patient enjoyed good health, but she belonged to a short-lived family, she being the oldest of ten brothers and sisters, all of whom died many years before she did. Fourteen years

ago she had a severe and protracted sickness caused principally by an acute inflammation in the right hypochondriac region. At the time, this inflammation seemed to pervade the duodenum and the pyloric orifice of the stomach. It evidently involved some portion of the peritoneum, as the severe pain, rapid pulse, tenderness and prostration plainly indicated.

Some light is shed upon this part of the case by the autopsy, which discloses a firm adhesion between the hepatic flexure of the colon and the fundus of the gall-bladder, and an almost entire obliteration of that cyst; in fact, the gall-bladder is reduced to the size of a small tube, and extends from the cystic duct to the fundus of the gall-bladder where it is adherent to the colon, where there has evidently been a free opening, so that that part of the bile which is usually held in reserve in the gall-bladder has passed directly from the cystic duct through the opening into the colon.

The most plausible explanation which I can offer for this state of things is, that just prior to the sickness spoken of above, gall-stones had accumulated in the gall-bladder to such an extent, or of such irritating character, as to set up inflammation in that organ, and by contiguous sympathy to induce the same in the colon and cause adhesions between them, which was followed by an ulcerative opening in the walls of each, so that the gall-stones and the bile passed freely into the bowel. This may account, in part at least, for the frequent attacks of jaundice which the patient had during the last fourteen years of her life. In the healthy or physiological state, bile is not found in the large intestine, and we know very well that the ascending and transverse colon are abundantly supplied with absorbent vessels so that the bile falling into the colon through this opening would be easily taken up and carried into the general circulation, and thus give rise to jaundice. About five years ago this patient, apparently from a severe mental shock, became much depressed; she lost her appetite, grew feeble in body, and at times was a little off in her mind. Tonics, stimulants, and tender care all failed to improve her, and travel was suggested. After a short absence among new scenes and new faces she returned much improved, but not quite well. She had now for nearly two years frequent attacks of jaundice, almost continuous dyspepsia, and some slight disturbance of the mental faculties; in fact, these symptoms continued with variations to the end of life.

About two years ago the mucous membrane of the mouth and pharynx took on an aphthous condition, which continued for a long time, and finally the surface of the tongue became ulcerated, and for more than a year that organ presented the appearance of raw beef. During this time there was not only a complete loss of appetite, but also a loathing of food and very imperfect digestion of the little food which passed into the stomach. Under the use of chalybeates, arsenic, mineral waters, bismuth, etc., and numerous mouth washes, these ulcers of the tongue healed and the papillæ and mucous surfaces appeared quite natural, but the sense of taste never returned. She could feel the food in her mouth but it had no natural taste; whether this loss of taste was caused by a morbid condition of the peripheral terminations of the gustatory nerves, or whether their deep-seated origins were at fault, it was impossible to tell. About one year ago this patient's hair began to fall off, so that in a few months ever spear had disappeared from the scalp; the eyebrows and eyelashes fell off also, and most of the hair from the other parts of the body, thus presenting a typical case of alopecia universalis. No disease of the hair follicles could be detected by the naked eye; the hairs seemed to drop out for want of nourishment, the follicles closed up and the scalp became smooth and shiny and remained so till death. A remarkable paleness pervaded the whole body at this time, giving unmistakable evidence of anæmia. About five months ago she began to lose the use of her upper and lower extremities, so that she was in a very short time unable to stand upon her feet or to feed herself with her hands. A partial paralysis plainly existed. After a continued use of electricity for three or four weeks she regained the use of her muscles so that she played a simple tune on the piano. This paralysis was more marked on the right side of the body. The small softening found in the left corpus striatum may have been the cause of this paralytic condition. This patient had finally some attacks of bilious vomiting, followed by great prostration; after one of these she went into a comatose condition and died of exhaustion caused by anæmia, which was found at the autopsy to depend upon the atheromatous condition of the large arteries supplying the brain and other parts of the body.

It is remarkable that during all these last years of her sickness her pulse was regular, soft and natural; only a short time before death did it become small and more rapid; and the heart, notwithstanding the mitral valve was loaded with atheromatous deposit, gave no abnormal sounds. I know of no set of symptoms which would enable the most astute diagnostician to tell what he was dealing with in a case like this.

The treatment of this case has been principally to mitigate symptoms, and it is a pleasant reflection to know that had we had a full knowledge of the pathological conditions we could not have done better.

Dr. D. S. Lamb presented a specimen of

EXTRA-UTERING PREGNANCY.

Mulatto woman, age 20, was admitted to Freedman's Hospital, D. C., September 25, 1885, with uterine hæmorrhage and acute peritonitis. After convalescense she went out of her own accord. Was readmitted November 27. Died February 19, 1886. A tumor was recognized above and to left of hypogastrium; this partially disappeared quite suddenly some days before death. She denied pregnancy.

Necroscopy by Dr. D. S. Lamb. Body well nourished; bloody fluid in pericardium; heart flabby; old firm adhesions of left lung everywhere; right pleuræ contained about a pint of dirty, bloody, purulent liquid; lung collapsed; abdomen much distended with gases, contained some bloody liquid; uterus enlarged; left fallopian tube converted into a large

sac with thick walls; placenta in left anterior portion; this sac had formed old cord-like adhesions to intestines, and also recent ones; it had ruptured posteriorly, edges very ragged; fœtus lying in abdominal cavity above and to left of uterus. The fœtus, ragged edge of sac, placenta and cord, liver, spleen and kidneys were far advanced in decomposition.

DR. J. F. HARTIGAN presented a specimen of

GUN-SHOT WOUND OF THE HEART.

J. C., æt. 14, was shot accidentally on the evening of February 20, 1886. Deceased was going up stairs when the revolver was discharged from the landing above. Immediately he whirled about, fled through the front room about twenty feet, and fell down the porch steps exhausted. He lived about four minutes.

The necropsy showed the ball to have entered the left border of the sternum, on a line with the cartilage of third rib; it then penetrated about the middle of right ventricle of heart, and, passing diagonally downwards, made its exit in the posterior aspect of left ventricle, near the apex; the anterior wound of the organ was an inch in length, the posterior an inch and three-quarters, presenting a chasm-like appearance from tissue destruction. Having wounded in succession the lung, liver and pancreas, the ball traversed the psoas muscle, fractured the crest of the ileum, and finally lodged in the glutens maximus, under the skin.

The case is interesting in two aspects: first, on account of the course of the missile, although this may be accounted for in a measure by the relative position of the perpetrator and victim; and secondly, the length of time deceased lived, and the extraordinary physical exertion following an injury of the heart such as has been described.

DR. J. FORD THOMPSON presented

AN OVARIAN CYST

from a patient on whom he had operated at the Garfield Hospital. The patient is a Scotch woman, 64 years old, the mother of seven children. Menstruation ceased ten years ago. Up to within the past eighteen months she enjoyed good health. At that time œdema of the left foot and leg was noticed, and soon after the abdomen became slightly enlarged. During the past three months she has been a good deal confined to her bed and has suffered much from nausea and vomiting.

This case is worthy of record on account of the very slight degree of constitutional disturbance which followed the operation. The operation was performed in the usual manner, except that in closing the wound, after ligating the pedicle and dropping it into the peritoneal cavity, three sets of sutures were employed. First, the peritoneum was closed by a continuous suture of catgut, the linea alba brought together by a second line of catgut sutures, and finally the external integument was approximated by interrupted silver and silk-worm gut sutures. The advantage of this mode of procedure is very obvious. The sutured abscesses, so-called, are avoided, or at all events, should abscess occur about the abdominal sutures, the entrance of pus into the abdominal cavity is prevented by the continuous suturing of the peritoneal surfaces. This mode of suturing the abdominal opening also renders the patient less liable to ventral hernia from imperfect coaptation of the parts. The patient was discharged cured in about a fortnight.

Stated Meeting, March 3, 1886.

DR. D. S. LAMB (through Dr. Smith) presented

A HEART WEIGHING THIRTY-EIGHT OUNCES.

It was removed from a tall, robust, dark mulatto man, who died February 20, 1886, of acute pericardial effusion. Aortic valve somewhat thickened, left ventricle much dilated. Aorta and branches somewhat atheromatous. Other viscera normal. Kidneys weighed thirteen ounces each.

Necropsy made March 1, 1886, by Dr. D. S. Lamb for Dr. T. C. Smith, on a mulatto woman about 45 years of age. Body somewhat emaciated, abdomen protuberant. Lungs showed firm old pleuritic adhesions and were full of cheesy tubercles and vomicæ. Heart appeared normal; not opened. Liver firm, anæmic; firm old adhesions everywhere. stomach and intestines generally collapsed and firmly adherent to adjoining viscera, abdominal wall, and tumor. Kidneys showed hydronephrosis, especially marked in left; ureters dilated. Uterus elongated, cavity five inches long; what appeared to be the body was of normal width; what appeared to be the fundus was enlarged by a large fibroid growth with thick capsule, in some places calcareous; its peritoneal covering thick, rough, whitish, dull-looking, and covered with patches of old lymph and many thick vascular bands; posterior and lower portion, left side, showed a large irregular cavity with calcareous wall and cheesy contents; the adhesions were most marked around this cavity. There were several small isolated tumors in left side of body of uterus (?) All the supplying vessels enlarged. Ovaries and Fallopian tubes not identified. Weight of uterus with tumor, sixteen pounds.

THE DRUG ALVELOZ.

DR. J. B. HAMILTON recalled to the Society the fact that some months ago he had introduced at one of the meetings, a man who had been suffering from a lupoid ulcer of the face. This patient had been treated with applications of alveloz, a drug which is indigenous to Brazil, and is there said to have a beneficial effect upon cancers, especially those of the epithelial variety. When presented to the Society the man was to all appearances practically well, the ulcer having cicatrized. Four months afterwards the sore reappeared. At that time the specimen of the drug which Dr. Hamilton had obtained from the State Department gave out, and he was unable to procure anything like it in the market. Indeed, no two specimens purchased by him resembled each other. None of them have had any effect. With the specimen obtained directly from Brazil, through the Department of State, Dr. Hamilton treated an epithelioma involving a part of the cheek, nose, and eye. Pain and hæmorrhage were almost constant symptoms. A few applications checked

the hæmorrhage and relieved the pain. The character of the granulations was entirely changed, and cicatrization was going on well. The American Surgical Association being in session here at the time, he showed the case to several of the members, who agreed with him as to the cicatrization. Dr. J. Collins Warren, of Boston, thought it a case of *noli me tangere*, a milder form of epithelioma. Dr. David Prince also saw the case. The patient was rapidly improving when the supply of the drug became exhausted, and the disease is now as bad as before. None of the recent applications have been at all useful. Upon investigation, Dr. Hamilton finds that other physicians have had the same experience, hence he concludes that alveloz as at present sold is either inert from deterioration, or fraudulent. It is a resinous "juice," or "milk," gathered at certain seasons, and may deteriorate. A fresh supply is expected soon to arrive. In reply to a question of Dr. Cook, he said his epithelial patient was said, in addition, to suffer from stone in the bladder, though he had not sounded his bladder. Moreover, his general health was not good. He had given him iodide of potassium whilst applying the alveloz. When the alveloz gave out he continued the potassium in large doses without effect.

Dr. S. S. Adams said that when Dr. Hamilton presented his first patient to the Society, Dr. J. Ford Thompson called attention to the fact that the ulcer was not completely healed and would doubtless return.

Dr. Hamilton said that the disease in this man had lasted for thirty years. There was no pus and only a small bulla in one corner when Dr. Hamilton brought him to the Society. He was content with the freedom from trouble for four months, and a drug is certainly valuable which can exercise such a remarkable influence on an intractable ulcer.

The American consul at Pernambuco sent specimens of the drug to the State Department, together with a history of the drug and its effect; this latter was written by a medical gentleman having a cancer hospital at Pernambuco. It has been printed and can be obtained by application to the State Department. The drug has been tried in France and England with varying results.

STATE MEDICINE.

PROPOSED NATIONAL BUREAU OF PUBLIC HEALTH.

A BILL TO PREVENT THE INTRODUCTION OF CONTAGIOUS AND INFECTIOUS DISEASES INTO THE UNITED STATES, AND TO ESTABLISH A BUREAU OF PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That there shall be established in the Department of the Interior a Bureau of Public Health. There shall be appointed from civil life by the President, by and with the advice and consent of the Senate, a Commissioner of Health, who shall be intrusted with the management of the Bureau herein established. He shall be paid an annual salary of four thousand five hundred dollars. For his use the Secretary of the Interior shall provide suitable offices, and, with the approval of the same, he shall employ such assistants and clerks as may be necessary.

Sec. 2. That it shall be the duty of the Department of State to obtain from the consular officers at foreign ports and places all available information in regard to the sanitary condition of such ports and places, and to transmit the same to the Bureau of Health; and said Bureau shall also obtain, through all sources accessible, including State and municipal sanitary authorities throughout the United States, weekly reports of the sanitary condition of ports and places within the United States; and shall prepare, publish, and transmit to the medical officers of the Marine Hospital Service, to collectors of customs, and to State and municipal health officers and authorities, weekly abstracts of the consular sanitary reports and other pertinent information received by said Bureau; and shall also, as far as it may be able, by means of the voluntary coöperation of State and municipal authorities, of public associations, and private persons, procure information relating to climatic and other conditions affecting the public health; and shall make an annual report of its operations to Congress, with such recommendations as it may deem important to the public interests; and said report, if ordered to be printed by Congress, shall be done under the direction of the Bureau. That the necessary printing of the Bureau of Public Health shall be done at the Government Printing Office upon the requisition of the Commissioner of Health, in the same manner and subject to the same provisions as other public printing for the several Departments of the Government.

Sec. 3. That the Commissioner of Health shall, under the direction of the Secretary of the Interior, frame rules which, when approved by the President and issued by the Department of State, shall serve for the instruction of consular officers of the United States and of the medical officers serving at any foreign port. In compliance with these rules, every master of a vessel destined for a port of the United States shall be furnished with a certificate containing a detailed statement of the inspection of the vessel, cargo, crew, and passengers, and of the sanitary measures carried out at the expense of the vessel; or if such measures are not carried out, instant warning shall be transmitted to the Bureau, who shall immediately notify the quarantine authorities of the port of destination.

Sec. 4. That the Bureau of Public Health shall, with the approval of the Secretary of the Interior, make investigations, both in the United States and, if necessary, in foreign countries, into the nature, origin, and prevention of contagious and epidemic diseases, as well as the causes and conditions of particular outbreaks of disease in the United States, and shall publish and distribute documents relating to the prevention of disease.

Sec. 5. That the President is authorized, when re-

quested by the Bureau of Public Health, and when the same can be done without prejudice to the public service, to detail officers from the several Departments of the Government for temporary duty, to act under the direction of said Bureau, to carry out the provisions of this act; and such officers shall receive no additional compensation except for actual and necessary expenses incurred in the performance of such duties. When a detail of suitable officers cannot be made, the Commissioner of Health may employ such experts, and for such time and in such manner as the funds at the disposal of the Bureau may warrant, subject to the approval of the Secretary of the Interior.

SEC. 6. That to defray the expenses incurred in carrying out the provisions of this act the sum of seventy-five thousand dollars, or so much thereof as may be necessary, is hereby appropriated, to be disbursed under the direction of the Secretary of the Interior, on the requisition of the Commissioner of Health.

SEC. 7. That an act entitled "An act to prevent the introduction of contagious and infectious diseases into the United States, and to establish a National Board of Health," approved March third, eighteen hundred and seventy-nine, and all other acts and parts of acts conflicting with the provisions of this act, are hereby repealed.

SEC. 8. That this act shall take effect sixty days after its passage, within which time the Commissioner of Health shall be appointed.

FOREIGN CORRESPONDENCE

LETTER FROM LONDON.

(FROM OUR OWN CORRESPONDENT.)

The Queen and the New College—The Old Colleges—Carelessness in Dispensing Drugs—Brain Surgery of the Stone Age.

The announcement that the Queen will lay the foundation-stone of the building which the College of Physicians and the College of Surgeons are conjointly erecting on the Thames Embankment has been received with marked satisfaction by the profession. It is to Queen Elizabeth that medicine owes its emancipation in England from many an old-world absurdity derived from Arabic and Pagan sources, for it was Elizabeth who, at the request of old Dr. Caius—the founder of the college bearing his name at Cambridge—sanctioned the practice of anatomy in this Kingdom, and thus laid the basis for a systematic scientific study of the body. It seems, therefore, quite in the fitness of things that another queen should lay the first stone of the new academic building in which the rival Colleges of Physicians and Surgeons have been merged. Times have changed since the days of Dr. Caius; the aid of the "barber chirurgeon" at the sign of the red and white pole or a "Jew-leech" skilled in simples is no longer sought. The pharmacopœia is not disfigured by the quack remedies found in the first edition, and compounded some of them of more than 120 ingredients. It is hardly possible to read of the rival Colleges of Physicians and Surgeons conjointly erecting an edifice for any common purposes without recalling the jealousy and bickering that led to constant quarrels in former days. The surgeons, or, more correctly, the barber-surgeons, were the older body of the two, for they were incorporated by a charter granted to them by Edward IV. The physicians were constituted a college by letters patent of Henry VIII. To put an end to the "irregular, unlearned and incompetent" practitioners who abounded in those days, he formed the celebrated Linacre with four others into a medical faculty. This provoked the ire of the surgeons, and quarrels grew apace. In Elizabeth's time there was a notable difficulty between the physicians and surgeons "whether a surgeon might give inward remedies in the sciatica, pox, or any other kind of ulcer or wound." The Bishop of London and the Master of the Rolls were both in favor of the surgeons, and old Dr. Caius, then President of the physicians, was called before "My Lord Mayor" and others of the Queen's delegates to "plead for his college." He did this so successfully that it was unanimously decided that it was unlawful for surgeons to administer medicines in the instances cited. After this the surgeons quarrelled with their colleagues the barbers and severed the connection. Then the two companies quarrelled so outrageously that Henry VIII reunited them again as a "Master and Commonalty of Barbers and Surgeons." They kept together till 1745, when the surgeons departed to the Old Bailey, and subsequently, in 1800, formed the body in Lincoln's Inn now known as the College of Surgeons.

The original College of Physicians was Linacre's Stone House, in Knightrider Street. The house was given to the Faculty during the lifetime of Linacre, who was one of Henry VIII's physicians. One of the most useful things the college ever did was to form a botanical garden in 1587 for the cultivation of rare plants of medicinal value. The garden cost "forty marks English money" a year, and the eminent herbalist, John Gerarde, had charge of it. After the Civil War the college was on the point of being sold as "church property" when a member, Dr. Baldwin Harney, became its purchaser. It was burnt down during the great fire, and rebuilt in Warwick Lane, near St. Paul's. In 1814 the college obtained from the Legislature power to hold its meetings in Westminster, and in 1820, through the efforts of Sir Henry Halford, the present building of the College of Physicians in Pall Mall was erected. The College can boast among its list of Fellows many whose names the entire civilized world holds in honor and would be unwilling to forget. Caius, Harvey—who bequeathed to the institution, along with other things, his "best Persian long carpet" and "pair of brass andirons with fire shovel and tongs of brass," Sir Thomas Browne, Sydenham, Sir Hans Sloane, Radcliffe, who was foolish enough to tell Queen Anne "he would not have her two legs for her three kingdoms," Pepys, Watson, Holland, and Arnott. The roll of the Physicians' College includes also the

Duke of Montagu, admitted in 1717, and the Duke of Richmond, in 1729.

An interesting report of an inquiry into the accuracy of chemists and druggists in the dispensing of medicines from physicians' prescriptions has recently been presented by Dr. Seaton. Within the past seven months Dr. Seaton has sent fifty prescriptions to various chemists and druggists and, in conjunction with Dr. Otto Hehner, has analyzed the medicines obtained. In order to carry out the inquiry in a broad spirit and without incurring any charge of splitting straws by cavilling at insignificant inaccuracies, the authors of the report drew the margin of error at 10 per cent. over or under the amount of the active drug prescribed in each case, and the deviations of wider mark than this have been singled out for comment. Out of fifty examples this limit was exceeded in seventeen—that is, in thirty-four per cent., while in eight of these cases, or sixteen per cent., the error exceeded twenty per cent. of the active ingredient prescribed. Some of these errors, except inasmuch as they implied a culpable carelessness, were medically of no great consequence, but some few were serious from a medical point of view. In one case pills were ordered, containing mercury and hyoscyamus. Owing to carelessness, the mercury was so unevenly distributed through the dozen pills ordered that some contained a third more mercury than they should have contained. In another case where corrosive sublimate was ordered the mixture contained one-third more than the prescription ordered. In a third instance where sub-acetate of lead was prescribed the mixture contained nearly sixty per cent. in excess. Of sulphate of iron there was found a deficiency of eighty-five per cent.

It is gratifying, however, to learn on reading further that the credit of the ordinary chemist is less assailed than may at first appear from the foregoing statements. Of the total number of fifty prescriptions thirty were made up at the shops of chemists and druggists, and among these thirty cases there were only two of serious error. At "doctors' shops," not yet obsolete rivals of legitimate pharmacy, two medicines were made up, one of which showed one of the gross errors already referred to. At the co-operative stores fourteen medicines were made up, which included three cases of serious error. Four prescriptions were submitted to a "drug company," and of these no less than three were inaccurately dealt with to the extent of more than twenty per cent. It would appear, therefore, that the public are safer in going to the shop of the ordinary qualified and registered chemist than in taking their prescriptions to the "doctor's shop" or to the coöperative store.

Professor V. Horsley has delivered an address on the "Brain Surgery of the Stone Age." Professor Horsley mentioned the fact that many of these apertures were in the part of the skull over the motor area, and thought that the operations were chiefly for traumatic epilepsy. G. O. M.

DOMESTIC CORRESPONDENCE

BRANCHES OF THE ASSOCIATION.

To the Editor of the Journal:

Dear Sir:—I have carefully read the letters which have followed the appearance of "Branch's" communication, and am rather surprised at the position which some of your correspondents have taken.

In his last letter (Journal of March 6) "Branch" states that his object is "to increase the influence of the Association, and organize the profession;" while he distinctly deprecates any idea of abolishing existing institutions. The only point on which I am not clear is where he says that "a very large amount of red-tape would be taken away from the requirements for admission to the Association when respectable and reputable physicians desire to enter;" the object to be attained is organization, and the results which inevitably follow where that is successful.

I am in perfect accord with your correspondent when he writes: "If anyone can propose a plan which will be more acceptable to the majority than the Branch system, I will certainly not raise my voice against it; but I do not see that a plan is *necessarily* bad because it is imported from Europe." No scheme can attain the end in view that does not provide for an executive meeting when required; to which business and legal matters can be entrusted. There are other objects for the American Medical Association than the mere advancement of science; but so long as that body only exists practically at an annual session, these objects must remain in abeyance. Dr. Hamilton considers that all we desire would be gained by admitting the members of affiliated State Societies; while Dr. Baxter advocates a regulation whereby members of the regular profession can join the Association without presenting themselves in person for election. These suggestions are embodied in the amendment permitting membership by application, which has been in existence for nearly two years; yet the number of applicants during that period is hardly what might have been expected. This would seem to show that some incentive is needed, and that the real advantages and benefits of membership in the National Association should be brought home to the profession.

"State Society" deals indirectly with the question of finance when suggesting a method by which the transactions of existing Societies, if incorporated, could be published in The Journal. I cannot agree with him that the stricter application of the doctrine of "survival of the fittest" will, in the long run, be beneficial. It would damage The Journal to print many of the papers found in the annual volumes of transactions of our State Societies; yet I think that the publication of these very papers is most desirable. Their production involves considerable time and labor on the part of the writer, who is usually not facile; and it is but slight encouragement to better work if they are consigned to the waste-paper basket.

The whole question of finance is the great obstacle to encounter, and the most difficult problem to

settle. I do not advocate the abolition of existing institutions, though I should be sorry to maintain them if a more effective scheme of organization can be found. The position of a State Society under the contemplated change, if that Society became a "Branch," would remain precisely as at present, except that every member would pay $5 annually to the treasurer of the Association; all their rights and privileges could be preserved, and their autonomy would be then, as now, complete. In any change which is contemplated, the same system of local representation would exist; and the profession in a given district would be *de facto* responsible for the ethical conduct and good standing of the members drawn from it. I cannot see how any of the "crooks and charlatans," whom Dr. Keller fears, would have any better chance of admission; while the salutary influence of the Association over them would be materially increased. "Illinois," whose letter contains very cogent figures, says "red-tape is thus reduced to a minimum, and yet there is no more probability of a bad man getting in than into one of our State Societies." This applies to the British Medical Association, and would be just as true of the American, if contemplated changes were carried out. A qualification for membership would still exist, and could be so arranged as to make some members personally responsible for the applicant. "Illinois" very properly deprecates what he terms the "holier than thou" sentiment. There are, in every community, physicians whose tendency to wander from the paths of ethical regularity, is unfortunate and marked. When these men are outside the pale of any medical organization, they are free; but once on the roll, it becomes possible to train and discipline them; and the punishment of formal expulsion for obstinate contumacy cannot be lightly regarded. I would always favor the largest possible membership for a Society in its district, believing that the best interests of the profession are thus more readily furthered.

An "Active Member" is the first correspondent who has formulated a definite scheme, and one which presents many excellent points.

The Triennial Congress is a good suggestion, and disposes of the inevitable clashing which would result between annual meetings of Branches and the National Association. Some plan on that basis would be most feasible, but further sub-division might be advantageous, especially in the more densely populated Eastern States. I do not concur with his suggestion No. 5, as I believe that once organized a Branch should have control of its own members, and their election; and that the qualification should be membership in a local Society.

"Medicus" lays down two purposes "to be aimed at" in any change which is to be made:

1. To so increase the numerical strength of the Association, as to make it, by virtue of its representative power, "the supreme authority upon all questions bearing upon the interests of medicine; and the professional and social deportment of its members."

2. "The advancement of medical science, and the collateral branches; and the elevation of the medical profession."

Both these purposes are to be kept in view, but the first is far more important. What the profession wants is thorough organization, and a permanent representative executive body.

Medical science is advanced in a general way by annual reunions, at which the rank and file of the profession are brought face to face with the great minds of the day; but save as an intelligent audience, it does not individually benefit them. Take the list of members at a State Society meeting, where one or two hundred are present; and see how few have papers to read, or cases to report, or will join in the discussions. The true source of medical cultivation is in the local society, which meets once or twice a month; when every member participates in the evening's proceedings, without that hesitancy which prevents many coming forward in the larger assemblies. Papers are read, cases reported, and criticism invited, while opinions are freely expressed, in a manner impossible except under these conditions. They promote harmony and good fellowship amongst the profession, maintaining its dignity, and defining its position, by following Art. VII of the Code. Nothing can supplant them, and any scheme which may be proposed will be strengthened by their incorporation as an integral part. Among the functions which the National Association performs, are those where matters of general professional interest are concerned; examples of which are well shown in an editorial in THE JOURNAL for March 6.

The profession wants representation, so systematized that when questions of vital moment and great public interest are involved it can meet the State or Federal Government, as an authoritative exponent of the wishes and opinions of its constituents. I believe that this purpose can in no way be so well served as by the establishment of Branches of the American Medical Association; and I think that the ends of medical science and medical policy will be best aided if these Branches are numerous, established in arbitrary districts, formed with due regard to the numerical strength of the profession in a given area, and meeting frequently, say three or four times a year.

Yours truly,

JAMES H. PARKINSON, L.R.C.S.

Sacramento, Cal.

TO THE EDITOR OF THE JOURNAL:

Dear Sir:—I have been much interested in the letter published in THE JOURNAL of Feb 6, and signed "Branch," relative to the establishment of a more intimate relation between the various State Societies and the American Medical Association. The plan which "Branch" has so admirably and clearly presented in his letter is almost identical with one which I have for some time carried in my mind, and which, but for the unfortunate state of confusion and dissatisfaction now existing in the profession, I would have ventured to lay before the readers of THE JOURNAL some time ago. To me, and I dare say to many others, the adoption of a plan by which the State Societies may become more closely affiliated with the National Association seems to be the best, and I was about to say, the only way of bringing the profession

again into that state of harmony so essential to the development of the great benefits which the Association may, and most certainly should confer upon the medical profession of America.

From a train of circumstances which cannot now be recalled, but are passed into history, the American Medical Association does not enjoy that degree of support and encouragement from the profession at large which its importance, as a scientific body, and its position, as the National representation of the medical talent of our country, assuredly merit and should undoubtedly receive. This desirable result can in no way be so certainly attained as through the active sympathy and hearty co-operation of the various State Societies in the aims and objects of the Association, which really is made up of, and exists only through the State Societies. If each State Society will accept and fill its place in the formation of the Association, there will no longer be cause for just complaint of the conduct or management of the Association. The plan proposed by "Branch" may be the best one, though it differs in some minor details from the idea which was in my own mind, and I would willingly see it adopted in place of the one I am about to describe, or I would gladly give support to a plan differing from either of these if it should seem that the good of the Association could be furthered by something else, better than by these.

I cannot think that at this time the State Societies will consent to be assigned a position as simple *Branches* of the American Medical Association. Their real position should undoubtedly be that of a Branch of the higher organization, of which they should be the willing adjuncts and essential components. The National Organization should have no being apart from that as the representative of the best and noblest elements of the State Societies, and should find its greatest pride and its highest honor in their celebrated distinction. The State Societies should feel an individual pride in the formation of the National body and an individual responsibility for its character and actions as the representative of the medical profession of the United States; and thus watch over and protect the Association from the hasty or injudicious acts of thoughtless or designing members.

The form which has appeared to me the best for the accomplishment of the above objects would be something as follows:

1. The American Medical Association is to consist of Branches corresponding to the several States and Territories of the United States.

2. Each State or Territorial Branch is to be the official local representative of the American Medical Association, and the diploma of membership in any State Medical Society is to be a title to Associate membership in the National Association.

3. Each State Society should be represented by delegates, according to the membership of the State Society; one delegate to be chosen for each. . . . . members of the State Society.

4. The delegates so chosen "pro rata" are to form the "council" or governing body of the Association, and to take charge of all its movements, subject to such restraints as may be thought judicious on the part of the Association.

5. From the delegates so appointed by the State Societies, the Officers of the Association shall be chosen, except the President, who may be chosen from without that body, or who may be elected in open meeting of the Association, by vote of the entire Association.

6. All members of State Societies who pay the dues of the American Medical Association, are thereby constituted Corporate members of the Association, and are entitled to take part in the transaction of business, and to receive the publications of the Association, and to enjoy all other rights and privileges pertaining to that body.

7. All other members of State Societies are thereby constituted Associate members of the American Medical Association, and may attend all the scientific meetings, and shall be enrolled in its catalogue; but they do not thereby gain the right to take action in its business meetings, nor to vote, nor do they receive the communications of the Association, or enjoy other privileges, except by permission of the coporate membership and the council.

8. The scientific labors of the Association are to be entrusted to committees chosen from the members of the council, from the Association at large, or from members of the medical or other professions outside the membership of the American Medical Association.

The plan here suggested, if it should be adopted, would have the effect of so enlarging the Association as to include the entire medical profession of the United States, so far as this is represented by State organizations as State Societies; and the diploma of membership in a State Medical Society would constitute the possessor of it at once an Associate member of the National Association, thus enrolling the entire State Medical Society membership in the membership of the National Association, as the body to which it naturally belongs, in this way attracting the profession to the Association, and inciting a more exalted degree of esteem and respect, and a greater emulation for that body, as the highest recognized medical organization of the country.

That this desirable object may be soon accomplished, and its beneficent results obtained is the ardent desire of many members of the medical profession in the

BAY STATE.

ASSOCIATION ITEMS.

RAILWAY FACILITIES TO THE ASSOCIATION MEETING.—For the next meeting of the American Medical Association at St. Louis Mo., from the 4th to 7th of May next, arrangements have been made with all of the principal railroads between the Atlantic ocean and Missouri river, to give delegates who pay full fare coming, return tickets at one-third fare. As yet the Commissioners of the Baltimore and Ohio, and Southern Passenger Association, not heard from. No doubt as to the same arrangements being made with them. In the next issue of this JOURNAL members will be fully advised of all arrangements with the various railroads. Delegates can come at any time they may wish before the meeting of the Association and

will be allowed five days after the adjournment of the meeting, before they will be required to commence their return trip. When purchasing tickets, get certificate from the railroad agent, at the starting point, showing the amount paid, the initals of road over which tickets reads, and office stamp where sold.

Other weekly medical journals please copy.

R. M. JORDAN, M.D.,
Chairman Transportation Committee.

St Louis, Mo.

RAILWAY FARES FROM CHICAGO TO ST. LOUIS.—The Illinois Central, Chicago and Alton, and the Wabash Railways have agreed to fix the rates from Chicago to the meeting of the Association, for members, at $7.50 *round-trip*.

THE GRANT COUNTY MEDICAL SOCIETY AND THE ASSOCIATION.—At a regular meeting of the Grant County, Indiana, Medical Society, on March 23, 1886, Dr. William Lomox gave a short history of the difficulty or misunderstanding between the American Medical Association and certain members of the Executive Committee for the International Medical Congress, and offered a resolution of approval of the action of the Association. The resolution was unanimously adopted. S. C. WEDDINGTON, M.D., *Sec'y.*

RAILWAY FACILITIES TO THE ASSOCIATION MEETING.—The regular through trains of the Illinois Central Railroad from Chicago to St. Louis will afford excellent accommodations for delegates who wish to attend the meeting of the American Medical Association at St. Louis the first week in May. The night express, with Pullman sleeping-cars, leaves Chicago at 8:30 P.M., and arrives in St. Louis at 7 A.M. The rates are $7.50 round-trip.

The rates on the Baltimore and Ohio Railway for those coming from the East and South-east are full fare coming and one-third fare returning.

AMERICAN MEDICAL ASSOCIATION.

The Thirty-seventh Annual Session will be held in St. Louis, Mo., on Tuesday, Wednesday, Thursday and Friday, May 4, 5, 6 and 7, commencing on Tuesday at 11 A.M.

The delegates shall receive their appointment from permanently organized State Medical Societies and such County and District Medical Societies *as are recognized by representation in their respective State Societies*, and from the Medical Department of the Army and Navy, and the Marine Hospital Service of the United States.

Each State, County, and District Medical Society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number: *Provided*, however, that the number of delegates for any particular State, territory, county, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association.

Secretaries of Medical Societies, as above designated, are earnestly requested to forward, *at once*, lists of their delegates.

Also, that the Permanent Secretary may be enabled to erase from the roll the names of those who have forfeited their membership, the Secretaries *are, by special resolution*, requested to send to him, annually, a corrected list of the membership of their respective Societies.

SECTIONS.

"The Chairman of the several Sections shall prepare and read, in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective Sections. . . ."—*By-Laws*, Article 11, Sec. 4.

Practice of Medicine, Materia, Medica and Physiology.—Dr. J. T. Whittaker, Cincinnati, Ohio, *Chairman*; Dr. B. L. Coleman, Lexington, Ky., *Secretary*.

Obstetrics and Diseases of Women and Children.—Dr. S. C. Gordon, Portland, Me., *Chairman*; Dr. J. F. Y. Paine, Galveston, Texas, *Secretary*.

Surgery and Anatomy.—Dr. Nicholas Senn, Milwaukee, Wis., *Chairman;* Dr. H. H. Mudd, St. Louis, Mo., *Secretary*.

State Medicine.—Dr. John H. Rauch, Springfield, Ill., *Chairman*; Dr. F. E. Daniel, Austin, Texas, *Secretary*.

Ophthalmology, Otology, Laryngology.—Dr. Eugene Smith, Detroit, Mich., *Chairman*; Dr. J. F. Fulton, St. Paul, Minn., *Secretary*.

Diseases of Children.—Dr. W. D. Haggard, Nashville, Tenn., *Chairman*; Dr. W. B. Lawrence, Batesville, Ark., *Secretary*.

Oral and Dental Surgery.—Dr. John S. Marshall, Chicago, Ill., *Chairman*; Dr. A. E. Baldwin, Chicago, Ill., *Secretary*.

A member desiring to read a paper before a Section should forward the paper, or its *title* and *length* (not to exceed twenty minutes in reading), to the Chairman of the Committee of Arrangements, at least one month before the meeting.—*By-Laws*.

Committee of Arrangements.—Dr. Le Grand Atwood, St. Louis, Missouri, *Chairman*.

AMENDMENTS TO BY-LAWS.

By Dr. Foster Pratt, Mich.—Each Section shall nominate its Chairman and Secretary—all other nominations to be made, as now, by the nominating Committee.

By Dr. I. N. Quimby, N. J.—Create a new Section, to be known as the Section on Medical Jurisprudence. WM. B. ATKINSON, M.D.,
Permanent Secretary.

1400 Pine St., S. W. cor. Broad, Philadelphia.

MISCELLANEOUS.

STATE MEDICAL SOCIETY OF ARKANSAS.—The Eleventh Annual Session will be held in Helena, on Wednesday and Thursday, April 28 and 29, commencing on Wednesday at 10 A.M.

NOTICE OF REMOVAL.—Dr. T. Gaillard Thomas has removed from 294 5th avenue, New York, to 600 Madison avenue, between 57th and 58th streets.